Representing Clients with Mental Illness:

A Resource for Louisiana Defenders

Co-produced by Louisiana Appleseed, the Louisiana Justice Coalition, and the Louisiana Public Defender Board.

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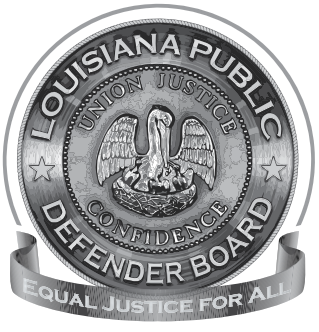

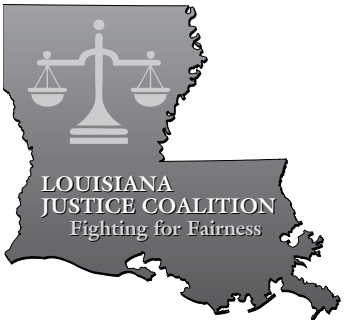

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Disclaimer: This booklet was co-produced by Louisiana Appleseed, the Louisiana Justice Coalition (LJC), and the Louisiana Public Defender Board (LPDB) to provide information about the law to the defender community.

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Although the booklet authors went to great lengths to ensure that the information contained within this booklet is accurate and useful, Louisiana Appleseed, LJC and LPDB do not guarantee against errors.

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Representing Clients With Mental Illness: A Resource for Louisiana Defenders

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A note about this handbook:

Representing clients with mental illness, particularly when they are poor and facing criminal, charges, can be a serious undertaking, particularly since mental illness may co-occur with mental retardation, drug addiction and related behavioral issues.

The subject is broad; this handbook provides limited information focused on more effectively providing legal defense services to indigent defendants with mental illness, though certain sections include information about related issues.

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Section 1:
Effectively Involving Mentally Ill Clients/Client Records into Legal Defense

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Part A. Initial Contact with a Client You Suspect Has a Mental or Behavioral Disability

Initial Contact

First impressions – The first contact with a client with disabilities is critically important to the development of a positive and productive relationship that will serve as a strong foundation for effective legal representation. Clients often turn "first impressions" into long term beliefs. If the client is a person with a mental and/or behavioral disability, he/she is more likely to form opinions about the attorney that are based upon erroneous thoughts and judgment. Whether these opinions are demonstrated through paranoia and suspiciousness or childlike naiveté with interpersonal boundary inclinations, the first impression can be critical to the success of the legal case.

For example, in the case of Robby, a client with mental disabilities (mental illness and mental retardation[1]), he formed an erroneous first impression of the defense attorney that was impossible to overcome. Robby had carefully watched the attorney in the courtroom before the two had a chance to develop any type of relationship, and he observed his attorney talking and laughing with the prosecuting attorneys prior to the beginning of the formal court proceeding. Robby determined that they were all working against him, and there was no way to dissuade him from this belief. Robby had, in fact, seen this with his own eyes! In reality, the prosecuting attorneys and defense attorney worked together frequently and had gone to law school together. They were simply sharing stories about their personal lives. The client adamantly maintained that his attorney was "in cahoots" with the prosecutor to put him in jail and no amount of persuasion could change his perspective.

Knowledge of prior arrests/behavior – It is not only preferable for the attorney of record to try to make contact with the client before the initial court appearance; it is also helpful if the attorney has time to examine the client's arrest record and any informal involvement with the law that occurred before the case under consideration. Prior arrest information can be very informative in the case of persons with

1 This handbook elects to use the term 'mental retardation' because that is how the condition is referenced in the Louisiana Statutes and the Code of Criminal Procedure. It should be noted, however, that advocates largely tend to prefer the term 'intellectual disability', or in some cases 'developmental disability'.

disabilities. For example, if the client has numerous low level contacts with the police over issues such as begging for money, trespassing (homelessness), disorderly conduct, or public intoxication, it is safe to question whether this person has a stable residence to which he/she will return, is unemployed or unemployable and/or if this person has some type of authority or substance abuse problem.

Other types of arrest reports can suggest mental disabilities involving cruelty, violence or aggressiveness. These are important behavioral indicators for every attorney to consider when making initial contact with the client. There are many psychiatric symptoms that can be linked to brain damage or some other type of neurological basis, including depression, obsessive-compulsive disorder, schizophrenia, visual and auditory hallucinations and bipolar disorder.

Initial Interview

The Environment – It is no surprise to legal counsel that the *environment* in which the first interview takes place is critical to communication and the development of a relationship. In many jails, lock-ups and prisons, the interview room is cold and uncomfortable and the client is often very fearful of being overheard or secretly recorded. It is important to speak to the jail administration if confidentiality is a concern as the client has to feel comfortable in order to talk freely with the attorney and other members of the legal team. Persons with disabilities may voice concern over an issue that seems silly or irrational; however, these concerns must be dealt with in a manner that assures the client that he/she is being taken seriously.

In addition to the importance of the physical environment, it is essential that the attorney establish a warm and trusting interpersonal relationship with the client. Small gestures, such as communicating with the client's loved ones or checking on family and reporting these activities to the client, help establish trust and understanding. However, it is also critically important that the attorney and other members of the legal team uphold appropriate interpersonal boundaries, for professional and personal reasons. Clients with disabilities often are unable to determine where the appropriate boundaries begin and end, so it is important for the attorney to establish these boundaries, letting the client know what the attorney's role is and how their relationship should proceed. This requires a delicate balance between professionalism and human compassion, a balance that is often even more difficult to maintain when a person has a mental disabilities.

Information Gathering – The attorney must pay close attention to early indicators that suggest the possibility of a disability. This is a more subtle aspect of information gathering that may present in ways such as poor eye contact, speech impediments, hearing or vision difficulties or an apparent inability to process information that is given to the client. Additionally, the attorney can listen carefully to what the client is saying and try to determine how his/her thought processes seem to be working. For example, persons with mental retardation often seem very eager to please the attorney with his/her answers. These early "clues" will help the attorney later with obtaining experts who can provide a proper evaluation of the client.

The attorney will generally collect some initial information about the client. This would include information such as:

- Date of birth
- Residence at time of arrest
- Social Security number
- Place of birth
- Marital status
  - Contact information for spouse
- Other family information

Children
Spouse
- Employment information
- Previous contact with the law
- History of illness

During the early stages of developing the relationship, it is generally best to avoid difficult questions, such as history of child or sexual abuse, sexual preference, or any degrading situations involving the client. For example, the client is unlikely to discuss honestly situations where he/she has been humiliated, e.g. sexual abuse by a parent, or where he/she has committed degrading or violent acts, incestuous relationships, animal torture or acts of pedophilia.

If the attorney suspects or has been informed of concerns with any type of behavioral health problem, it may be better for the client if the first meeting is kept relatively brief and superficial. This will give the client time to reflect on the first meeting with the attorney and become accustomed to the relationship.

After the attorney has had several visits with the client, if he/she thinks the client has some type of disability, it is important to call in assistance to help the diagnostic process. In capital cases, the best person to contact first for assistance is a mitigation specialist. This person can spend more time with the client and complete an initial assessment that will guide decisions about what type of experts may be needed. In non-capital cases, it also may be helpful to hire a mitigation specialist, social worker or related licensed professional who is well trained in the development of a case history. Hiring professionals to help develop case history information requires some knowledge of the professions. For example, social workers are generally well trained to work with a client in his/her home environment or community. It is critically important for the attorney to know about each profession's education and training programs and how various credentialed professionals can be helpful to the client.

Assessment and Interview Protocols

In many cases, the attorney or another member of the legal team observes some subtle behaviors or responses that lead them to question whether a person might have some type of mental and/or behavioral disability. If the members of the legal team do not have resources to hire a professional to help, there is a course of action they can pursue to try to persuade the court that funding is needed for professional help to determine a client's capabilities. The attorney or other designated member of the team can follow a logical, basic interview format that would gather the information needed to prepare a report for the court in order to ask for additional resources.

As discussed previously, obtaining valid information from a client requires a trusting relationship between the person asking questions and the client who is trying to decide how and what to answer. Sometimes the attorney is the best one to try to obtain the information; other times it is best to use another person on the defense team if there are no resources to hire a specialist or expert. Other possibilities may include an investigator, staff mitigation specialist or experienced support staff. Cultural issues can have a significant influence on the client and it is often best to connect the most culturally appropriate person to the client. Cultural issues may include race, gender, age, educational status and ethnicity, among other factors.

For example, in the case of Robby, the attorneys, investigator and mitigation specialist could barely evoke one word out of their 18-year-old client. He was small, illiterate and scared to death. Although arrested for his part in a homicide, he had never been in jail and had rarely been away from his mother. When the mitigation specialist began to suspect that Robby could not read and could barely write, she enlisted the aid of the office manager, who was a former special education teacher. With this person's guidance, the mitigation specialist and attorney were

able to frame questions in a more effective manner and assist Robby in providing information.

The questions that a member of the legal team would be asking at this point are basically informative and factual. They are aimed at gathering enough information to determine if the client has a disability. Examples of brief interview forms for clients and their families (McRainey, 2007[2]) are included at the end of this section.

An interview protocol used in mitigation (Guin, 2007) is also included at the end of this section. This is a more extensive list of all of the questions asked to prepare a mitigation report (also known as a disposition report). These questions will guide the mitigation specialist or other licensed helping professional to gather all of the data for a comprehensive report.

It is important to reiterate how critical it is to provide the proper foundation for questioning. Most clients will not answer questions completely or honestly if they do not have a relationship with the person asking questions. Additionally, they rarely answer personal questions honestly early in the relationship. If the client has a mental disability, answers to questions are even less reliable. The reliability of answers has to do with trust and the characteristics associated with the disability. For example, persons with mental retardation may answer questions in a way to "please" the questioner, with their responses often being completely untrue, greatly exaggerated or simply compliant.

If the attorney can gather information with his/her own resources and present that information to the judge in a way that demonstrates the indications of a mental or behavioral disability, the judge will often find the resources for professional assistance in the case. Indications of medically related problems are particularly important, such as seizure disorder or brain damage.

Indicators of Disabilities

The array of disabilities is extensive, often causing confusion among those who periodically work with persons with disabilities and who do not work in a related field. Sometimes it is difficult to differentiate the exact type of disability among clients, particularly with the increasing incidence of dually diagnosed persons entering the justice system. Mental illness, mental retardation, addictive disorders, developmental disabilities and dual diagnosis categories are but a few of the terms describing specific disabilities. More recently, the term "behavioral health" has emerged as a catch-all phrase encompassing several of the types of disabilities. This label refers to mental illnesses and addictive disorders, as well as mental illness or addictive disorders with co-occurring developmental disabilities. In short, diagnosis of the correct disability requires the services of an expert because of the complexity of the issues.

Since it is not always plausible, possible or desirable to hire an expert early in the legal process, attorneys must become better trained in recognizing the overt signs of mental and behavioral health issues. Additionally, it is important to substantiate the types of behaviors or characteristics that the client presents to ensure that the right expert is called upon at the appropriate time. Thus, attorneys and others who have contact with the client should be trained to look for signs of a disability and to record the behavior or trait that has been noticed.

For example, in the case of Robby, an investigator for the defense attorney was puzzled when Robby kept reporting that he was urinating on himself at odd times, but he couldn't remember feeling the need to urinate or the actual incident. A note was made of the behavior but little attention was paid to the report because the client was so uneducated and difficult to understand most of the time. When a psychologist was eventually hired to conduct psychological testing on Robby, he actually observed the client having a non-convulsive seizure, which ended with Robby urinating on himself. It was discovered that the jail was not consistently providing Robby with the medication that he had been taking for many years because of grand mal seizures that had been diagnosed

2 For full citations within this section, please see Part D: Resources at the end of this section.

very early in Robby's life after he suffered brain damage from eating rat poison. Had the investigator or attorney had any training in recognizing signs of mental impairments or had any knowledge of the medication Robby was taking, he/she would have surely suspected that Robby was experiencing some type of seizure and obtained medical expertise initially.

For reasons, such as those discussed above, as well as the concern of having probation or non-secure sentence requirements imposed that the client is incapable of meeting, it is very important for attorneys and their staff who deal with persons with disabilities to obtain basic training. This training only needs to pertain to collecting pertinent information and recognizing signs of a mental or behavioral disability. The McRainey (2007) interview forms at the end of this section are easy to use and would provide some indication of a problem. Additionally, attorneys and their staff should be trained in recognizing the overt signs of a disability in the event the problem is not revealed during initial contact.

Behaviors or characteristics shown by clients that often cause the attorney to question the possibility of a disability (Logan, 1992 and Stetler, 1999) include:

- Reality confusion – hallucinations, hearing voices, seeing things, false sensations, illusions, phobias, irrational fears, delusions, consistent false beliefs
- Speech and language problems – incoherence, illogical speech, nonsensical speech (e.g. new word formation), poverty of speech and thought (alogia), half answers, changing subjects midsentence, irrelevant answers, loss of goal, persistent and/or inappropriate repetition, pressured speech, rapid and/or racing speech, blocking, substitution of inappropriate words, slurring, monotone, dyslexia
- Memory and attention issues – amnesia, filling in details of faculty memory; extraordinary ability to recall, limited attention span, selective inattention on emotionally charged issues
- Medical complaints – hypochondria, self mutilation, accident proneness, anorexia and changes in eating habits, blurred vision, hearing problems, ringing in ears, headaches, dizziness, nausea, fatigue, loss of control of bodily functions
- Inappropriate emotional tone – anxiety, suspicion, depression, hostility, irritability, excitement, flat affect, emotional instability, inappropriate laughter
- Personal insight and problem solving difficulties – self esteem too high or too low, frustration, denial of mental problems, difficulty planning, difficulty changing plans when necessary, impaired ability to learn from mistakes
- Problems related to physical ability – agitation, hypervigilence, psychomotor retardation, slow reactions in movements or while answering questions, clumsiness, tension
- Unusual social interactions – isolation, estrangement, difficulty perceiving social cues, emotional withdrawal, disinhibition

Persons who have had little experience working with persons with mental and behavioral disabilities often confuse mental illness and mental retardation. It is possible to have both diagnoses, but generally the two disorders present very differently. Since the two diagnoses are often simultaneously present, some information related to mentally retarded clients is included below.

Mental illness refers to a medical condition that disrupts a person's thinking, feeling, mood, ability to relate to others and daily functioning. The illness reduces a person's capacity to cope with the ordinary demands of life and presents across a continuum of severity (NAMI, 2007). The type of mental illness is diagnosed according to the Diagnostic and Statistical Manual of Mental Disorders (DSM) published by the American Psychiatric Press.

Mental retardation (MR, also referred to as developmental or intellectual disability) refers to people who have below average intelligence and who usually have difficulty with basic daily living skills. It is diagnosed through testing that establishes the level of retardation. The four levels are:

- Mild – IQ between 50 and 75; generally function between 3rd and 6th grade level (87% of persons with MR)
- Moderate – IQ between 35 and 60; cannot function alone, must be supervised (10% of persons with MR)
- Severe – IQ between 20 and 40; limited ability to communicate, must be well supervised
- Profound – IQ below 25; very few skills or abilities, must be supervised constantly

MR is diagnosed in childhood most of the time, unless brain damage occurs due to an accident or illness later in life.

According to the American Association on Intellectual and Developmental Disabilities (AAIDD, formerly the American Association on Mental Retardation), individuals with mental retardation often:

- Are easily led, willing to talk, and have a poor understanding of cause/effect and consequences of their actions, often putting them at higher risk of unjust incarceration
- Are impulsive, which may result in acts that people of average intellectual abilities could refrain from
- Will attempt to hide their disability to avoid the stigma of the disability
- Exhibit low self-esteem, poor tolerance for frustration, desire to please authority figures and often will acquiesce to the wishes of other individuals who are perceived to be more influential

These behaviors are the primary reason that persons with mental retardation are arrested more often and provide false confessions. (Edwards, B. & Fowler, D., 2007)

Interacting with a Client You Suspect Has a Mental or Behavioral Disability

Attorneys and their staff who observe or question specific behaviors should make a note and compare their observations. Isolated incidents of strange behavior are certainly not to be construed as some sort of disability, but when observations are consistently made or questions consistently raised about a client's overt or more subtle traits, the information is very helpful in finding the right expert to diagnose a suspected problem.

If, through record review, interview or observation, the attorney suspects that the client has a mental disability, it is important to document these suspicions to share with the court or with a mental health expert.

If a good relationship with the client has been established, the attorney may be able to ask some pointed questions (using language suitable to the apparent IQ level of the client), such as:

- Do you recall if you have ever been treated for a mental or emotional problem? Another way to phrase this question might be: Have you ever talked to a counselor or social worker about any problems?
- Do you receive a check every month for any type of problem you may have?
- Have you ever had to go talk to someone because you drink too much or use drugs?
- If yes, ask if the client spent the night when they went to get help.
- Has anyone ever told you that you have a problem with the way you think or act?
- If yes, ask if the client remembers what type of problem was identified.
- Do you take any pills or medicine? Do you know what it is or why you take it?
- Do you remember ever taking any medicine? When and what for?

- Have you ever been sent to a hospital? Do you remember why? Where is the hospital? Do you know how long you stayed there? Do you know what you were treated for?
- Are there any family members or friends that you would feel okay about me talking to?

When speaking with the client about any mental, developmental or emotional difficulties, the attorney should use terms with which the client might be familiar, especially local facilities. For example, in Louisiana, psychiatric patients are often committed to facilities in Pineville (outside Alexandria) or Greenwell Springs. If it is an older client, he/she may recall the psychiatric ward at "Big Charity" in pre-Katrina New Orleans. Other terms with which to be familiar might include group homes, substance abuse facilities, local jails and local hospitals that have a psychiatric ward.

The manner in which the attorney speaks to the client is also very important. If the client perceives of the attorney or other members of the legal team as snobbish, disinterested, cold or arrogant, he/she will avoid sharing any personal information. Persons with mental and behavioral disabilities are often embarrassed about their condition, lack of education or inability to understand what is being said. When speaking to these clients, the strategic use of words is critical.

For example, if the client is asked questions such as: "Do you have a mental problem? Has anyone ever told you that you were crazy? Do you get a 'crazy check' every month?", it is unlikely that the client will admit to any of these difficulties.

If the attorney uses questions that are more tactful, such as: "Have you ever had a problem that you needed to talk with someone about? Do you remember ever feeling really sad or confused for a long period of time, but you did not know why?", he/she will have a much better chance of getting strategic information that may lead to uncovering a mental or behavioral difficulty.

Other communication tips include:

- Speak slowly and simply
- Maintain good eye contact
- Repeat questions slowly if necessary
- Demonstrate patience
- Respond positively to honesty
- Ignore suspicions about malingering, dishonesty (a mental health expert can figure this out)
- Speak honestly and openly
- Avoid negative connotations or jokes about mental or behavioral difficulties.

Gathering Information on Your Client/Where to Look for Confidential Information

If, after meeting with the client and conducting an initial interview with the client's family, the attorney suspects that there is some type of mental or behavioral disability, it will be very important to substantiate these concerns. It is equally important to rule out the presence of any type of debilitating disability. More detailed information about the client can be gathered through face-to-face interviews with selective persons and through the attainment of official records describing certain aspects of the client's life, e.g. school and medical records.

A key rule governing the attainment of information about the client is obtaining the proper consent. First, the attorney or mitigation specialist should explain to the client who will be contacted for interviews and the purpose of the visit with another person. The client must sign an authorization form that gives the attorney or other professional permission to talk about the case. The client should know the intent of the interview and what will be discussed with family members, friends and other

connected persons.

A comparative rule for the attainment of records is not only that client authorization must be obtained, but also that the records obtained are stamped as "Certified Copies." This will ensure that the records obtained are the same records the prosecutor could obtain. It also ensures that the attorney has all of the records being requested.

Interviews:

Generally, the best place to begin the search for confidential information is with the client's family. Through careful questioning of individual family members, the attorney or other professional may be able to obtain information that helps decide if the client has some sort of disability.

It is very important to develop a basis for trust with the family members so they will feel comfortable discussing confidential information with the attorney. Various family members may recall childhood stories or accounts from school that provide additional information about the client. Family members may be able to provide information about any of the specific types of markers for mental or behavioral difficulties that have been evident with the client or information about a family history of mental, emotional or behavioral problems.

Consider the following examples:

- Early school related problems with achievement or behavior
- Participation in counseling sessions
- Visits to a local mental health clinic
- Incidents of passing out or seizure type activity
- Special education classes
- References to the client as "special needs" or "off" or some other slang terms that are used to describe a person with disabilities
- Incidents of aggression, bullying, violence
- Incidents of being bullied or made fun of by others
- History of illnesses
- History of accidents
- Family history of illnesses
- Medication history
- Family stories about "crazy Aunt Sally"
- Hospitalization
- Social Security Disability Insurance (SSDI) check

In addition to family members, interviews can also be scheduled with teachers, neighbors or other significant representatives from the community. If the client has remained in jail, an informal discussion with the jailers may yield a great deal of information.

For additional guidance with interview questions, please refer to the Client and Family Interview Forms and Forensic Interview Protocol at the end of the section.

Official Records:

Based upon the interviews with the client, family and others, a list of potential official records should emerge that may have further information about the client. Most agencies have their own set of rules governing the ordering and attainment of records, and the attorney will need to obtain the rules. Some rules within the same agency vary by parish. For example, one Department of Children and Family Services (DCFS, formerly Office of Community Services [OCS]) regional office may require a signed

authorization from the client, while another may require a court order.

Copies of official records may be obtained from the following agencies:

- **Local schools** – generally the request goes to the local school board; some parishes maintain the records at the last school attended.
- **Medical** – check with the client's physician of record, local hospitals and any other medical clinics the client or his family have identified. Examine any hospital records closely for signs of a seizure disorder, head injury or unusual incidents related to brain damage, such as eating rat poison. If warranted, a search of local hospital records should include the emergency room, particularly if the client lived in Katrina/Rita-affected Louisiana. The emergency rooms and local jails have become substitutes for persons in need of treatment for substance abuse and mental disabilities. Since resources for dealing with addictive disorders and behavioral health problems are virtually non-existent or overcrowded, persons in need are being propelled into local jails and emergency rooms for treatment.
- **Birth** – the birth record is generally maintained at the hospital where the birth occurred. These records can be very significant in the identification of mental or behavioral disabilities. Fetal or birth trauma is generally described in these records. Also, the Apgar score will reveal if the newborn baby was experiencing any difficulty.
- **Neglect/Abuse Agency** – Louisiana Department of Children and Family Services (DCFS, formerly the Office of Community Services within the Department of Social Services. These records are generally very thorough and often require a court order to obtain. The records can reveal information related to disabilities, such as malnutrition, child abuse, extreme poverty. It is often possible to get the parents of the client to sign a release for their DCFS records. These records are very helpful because they may offer additional family historical information related to genetically related causes of disabilities.
- **Mental Health** – mental health records are critical, but unfortunately the state's policy allows the destruction of mental health records in a relatively short period of time. The time varies, but the records are rarely kept for over 5 years. Mental health records are secured from the Louisiana Department of Health and Hospitals (DHH), Office of Behavioral Health (OBH, formerly Office of Mental Health) if they are available. The OBH can also refer records requests to several of the state forensic hospitals (Greenwell Springs, Mandeville, Pineville) in the event the client has been hospitalized for a mental disability.
- **Law Enforcement** – unless there is no evidence to suggest any prior involvement with the law, the attorney should request *local arrest and jail records*, as well as state level records. Minor arrests at the city or parish level can provide a wealth of information on the client's behavior, especially any behavior that is deviant or suggestive of mental or behavioral problems. The minor arrests often are only recorded at a local level, but these arrests may be much more informative about the client's potential for mental or behavioral disabilities. It is always important to obtain state *Department of Corrections' records* if they exist. A record of the client's behavior while incarcerated can yield some very useful information. When requesting official records from a jail, lock-up or state prison, the attorney must be sure to order all records, including education, medical, progress, mental health and related information. This information is often housed within a department in the prison system, as opposed to a centralized file. The attorney should also check for the existence of *probation and parole records*. These would include a more descriptive account of the client's behavior outside of a structured prison setting. If there is an indication that the client has a *juvenile record*, these records should be obtained though local police, local juvenile courts/courts with juvenile jurisdiction and the Office of Juvenile Justice (OJJ, formerly Office of Youth Development). Separate records are maintained at each of the juvenile correctional facilities and would need to be subpoenaed through OJJ's legal office for Bridge City Correctional

Center for Youth [BCCY] (formerly Louisiana Training Institute Bridge City [LTI-BC]); Jetson Correctional Center for Youth (formerly LTI-Scotlandville); Swanson Correctional Center for Youth [SCCY] (formerly LTI-Monroe). Additionally, Tallulah Correctional Center for Youth [TCCY] (renamed Swanson Correctional Center – Madison) is no longer open, but housed a great number of children and youth with disabilities.

- **Employment Records –** if the client has been employed, these records may be of use in establishing behavioral patterns, especially if the client initially functions in an acceptable manner and then falls into an increasing pattern of behaving inappropriately. Substantiation of deteriorating mental and behavioral status over time is excellent substantiation of mental illnesses with an adult onset. The often subtle changes that take place over time show up very well in job related performance.
- **Department of Children and Family Services (DCFS, formerly Department of Social Services [DFSS]) –** if the interviews or other sources of information suggest that the client receives a monthly disability check from DSS, these are essential records to obtain. In order to qualify for the SSDI public assistance, an evaluation must be performed on the client to evaluate his/her capabilities. If the client receives this type of public support, there really is no doubt that he/she suffers from a mental disability.
- **Military Records** – if the client was in the military, his/her records may be invaluable in substantiating a disability. First, if he/she had a disability prior to entry, it will most likely show up in some manner in the military file. Often the disability does not show up until the person is placed on active duty. Prime examples of disabilities that emerge during military service include anxiety and depression disorders and various types of physical problems. If the client has been sent to an area overseas where there is active warfare, there is a great chance that he/she has a trauma related disability. Military records are complicated to obtain. The attorney will need the client's specific authorization. To obtain the records, the attorney or mitigation specialist should contact the particular branch of the military and it will send its requirements or forms. Attainment of military records generally takes a long time.

Attainment of Records – Be Careful What You Ask For:

If the attorney obtains official records, particularly through court order, the prosecution will most likely have access to the information. Make sure any information that is requested and planned for use in the courtroom will be more helpful than harmful to the client. For example, if there is a possibility that the DCFS (neglect and abuse) case history will reflect instances of childhood violence that can be attributed to the client, the prosecution will be less likely to take a chance on treatment-oriented alternatives. In spite of the fact that the attorney may know that the client was not involved with childhood violence, the mere hint of involvement can seriously impact the outcome of negotiations for treatment-oriented sanctions. This is another reason why it is so important to collect face-to-face information from family members. It is critical to know what records are being ordered and what information is being sought.

Obtaining records is often a long, complicated process, so it is important to start on this as soon as possible and to follow up with the request continuously so it is not ignored or forgotten.

General Research for Information that Will Support Your Position:

In certain types of cases, research into demographics and empirical forensic literature may be very helpful. This is especially true in death penalty mitigation and in recommendations for sentencing alternatives.

In developing sentencing recommendations or alternative sentencing recommendations, it will be helpful to conduct research into sentencing options that have proven to be successful in similar cases. For example, restorative justice-based sentencing options have shown very effective outcomes. Instead of sentencing a man with four children to prison, it would make more sense to provide support to help him get a job and perhaps serve jail time on the weekends. For many people with disabilities, the standard treatment simply does not work. For someone with educational disabilities, requiring him/her to agree to a plan that will never work because of poor memory, inability to read or inability to navigate public transportation sets the client up for failure and for continuous cycling in and out of the local jail.

In restorative justice, the sentence is usually structured so that there is a logical link between the crime that has been committed and the sanction. For example, in DWI cases, the client may be sentenced to working in hospital emergency rooms as a volunteer on weekend nights. For someone with disabilities, a sentence might be crafted that would place the client in a position to work at a group home for adults with disabilities or at one of the state's institutions. These types of sentencing alternatives must be creatively developed and worked out with all of the involved agencies prior to sentencing.

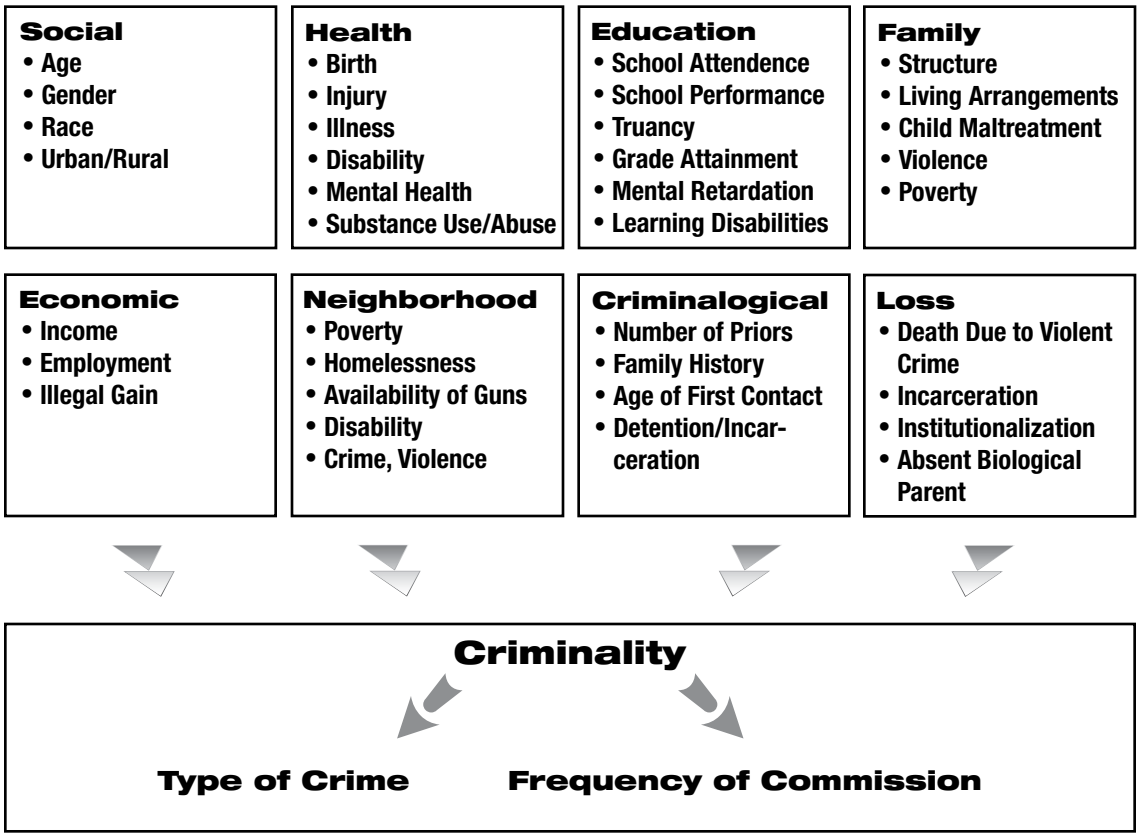
Research into the effects of a certain disability may be helpful. By explaining to a judge the effects of certain disabilities, such as bipolar disorder or severe depression, it may help in the attainment of a more humane outcome, e.g. house arrest, security bracelets, medicine checks, electronic surveillance. The goal of research into specific disabilities is to obtain a sentence that will prevent the problem from happening again as opposed to exacerbating a problem.

Demographic research may produce information about the client and his/her disability and how he/she compares to the community or some other segment of the population. How are closed head injuries defined and how many cases are there in East Baton Rouge Parish? How do diverse cultures deal with certain types of disabilities? Are males or females more prone to certain types of disabilities? How does this compare across race?

In death penalty mitigation, attainment of records and research into the client's background is essential. The goal in death penalty mitigation is to develop a life story that clearly shows how the client got to this place in his/her life and how present circumstances are connected to a commission of a homicide. For example, is there a pathway of behaviors that clearly show the onset of schizophrenia? Were there early life events that created the behavior that a client may be showing?

The theoretical framework underlying the development of a criminal personality is a helpful guide in examining a client's life events, activities and characteristics that are causally related to the crime at hand. The following factors have been empirically linked to the development of a criminal personality, thus they must be examined in any of the more serious criminal cases.

Factors to Examine Related to Criminal Development



Once this information is gathered, it can be placed in a variety of different types of reports and presentation formats. The first example shown below provides a structure for a written report on a client's life. The second example is a more graphical display of a timeline that attempts to present a logical life sequence for one client's pathway to arrest and conviction for a first degree murder. Typically, the written report should include descriptive narrative that elaborates upon the graphical timeline information.

Sample of Methods of Description in Life History Report

CONFIDENTIAL
Name of Client
Life History Report
November 2002

Purpose

This report is being written at the request of Mr. _____, defense attorney for Mr._____, Client. The client is currently incarcerated in the Parish Jail on legal charges for first-degree murder. He has been in jail on this charge since April 1999. I met with the attorney on August 1, 2000 for the initial discussion about our availability to provide mitigation expertise in the client's case. I agreed to accept the case, with assistance from others in my office at LSU, the Office of Social Service Research and Development (OSSRD). However, I advised the attorney that it would be at least 12-18 months before we could be ready for a trial because of our existing caseload.

Specifically, the attorney hired me to develop a forensic social history on the client. The completed comprehensive social history would then be used to assist the attorneys in developing mitigation evidence for a possible penalty phase. As a forensic social work expert, I also agreed to assist the attorney and co-counsel in understanding the empirical relationship between our client's life history and the development of a criminal lifestyle. I explained to the attorney that our involvement included a commitment to work with the client and his family to psychologically prepare for a capital trial and the possible outcomes. Finally, I advised the attorney that I would recommend the hiring of any other experts that I felt were necessary to substantiate our client's social and psychological status.

Methods

The methods I use to develop a forensic social history include extensive data collection and interviewing to obtain the initial information that is needed to establish a chronological profile of the individual's life. I rely on standard social work case history procedures and a theoretical framework that empirically links the pertinent categorical life factors to the development of a criminal lifestyle. The life factors that I examine are depicted at the end of the section and are referenced as Guin, 1991, Guin and Merrill, 2002 and Guin, Noble and Merrill, 2003.

As the initial life chronology is being developed, I am able to identify sources that will substantiate the verbal reports that are provided to me. By asking the client and each family member individualized, open-ended questions, I am generally able to determine which "hard records" I can order related to birth, early childhood, education, medical history, family related issues, criminological history, military history, economic status, child maltreatment and mental health. I begin the process of ordering records, reviewing them and re-ordering records until I believe that every available hard record on my client and his family is in my possession. This approach is effective, in terms of record gathering on my client, but the attainment of information on family members requires their authorization. Depending on the age of the client, some of the records have already been destroyed. In our client's case, many early records could not be located.

As I speak to the client or his family, I generally can identify other sources of information who are non-family members. This might include, neighbors, teachers, friends, school bus drivers and medical doctors.

The information used in the final social history is based upon hard records and on substantiated information or information that has been individually reported by 2-3 different sources. When something is reported that has not been verified, I generally document from whom the information was obtained.

These are well-established data collection methods in the social work profession. In this case, I relied upon the following records:

- Certificate of live birth
- Office of Human Development, Division of Children, Youth and Family Services (now called Department of Social Services, Office of Community Services)
- Medical Records from a local medical center, Anonymous, Ph.D.
- School records from three parishes
- Parish District Court, with Juvenile Jurisdiction
- Parish Sheriff's Department
- Parish Police Department
- Department of Public Safety and Corrections, including records from LTI-Bridge City (now called Bridge City Center for Youth), the Juvenile Reception and Diagnostic Center at LTI-Baton Rouge (now called Jetson Center for Youth), Elayn Hunt Correctional Center, the Adult Reception and Diagnostic Center
- Christian Acres Home for Boys, Joy Home for Boys, La Garconiere Group Home, Baton Rouge Developmental Centers

I, or a member of my staff, interviewed the following persons:

- The client
- His mother
- His 5 siblings
- Maternal Aunt
- Father
- Girlfriend
- Secretary at the Middle School
- Employee of the Middle School
- P.E. teacher at the Middle School
- 1st cousin (female)
- Cousin's son
- Classmate
- Maternal Grandmother
- Uncle
- Maternal Aunt #1
- Maternal Aunt #2

From this information the following life history sections have evolved: Family of Origin; Birth and Early Childhood; School Years; Adolescence, and; Late Adolescence/Early Adulthood.

Summary

This client evolved from generation after generation of family members with disabilities. In many cases, these individuals and families had become dependent on government subsidies because of their inability to care for themselves. In the client's immediate family, there is every indication that most of the children were in Special Education or were, at a minimum, suffering from serious learning disabilities. The learning and intelligence issues have been exacerbated by the poor health of many family members. One of the client's brothers is terminally ill with cancer. Another brother is in a chemical dependency facility in Bayou Vista. Finally, the client's mother is a long-term alcoholic who is in poor health.

The client appears to function in a higher capacity because he has adapted to his disabilities by improving other skills. For example, he presents as a personable and somewhat charismatic person. He is extroverted and appears to have good leadership abilities and reasoning skills. Nonetheless, his life history clearly indicates the presence of a disability from the earliest time of his life that is documented. He has experienced multiple head injuries and was, in fact, critically ill from some sort of brain trauma when he was under the age of one year. There is little doubt that some of these problems emanated from his mother's abuse of alcohol when the client was in utero.

The environment in which the client was raised was quite disruptive. This is most evident from the multiple records that we obtained from the Office of Community Services. The client was abused from an early age and seems to have suffered greatly while living with Aunt #1. He went from this situation to multiple out of home placements, which were ineffective and often cruel. The lack of education, unstable environment, birth and accident-related head injuries and poor socialization have led the client to this point in his life.

It should be noted that the client has consistently denied any involvement with this homicide. He maintains that, in spite of his economic-related criminal history, he has not been involved with violent acts upon other persons.

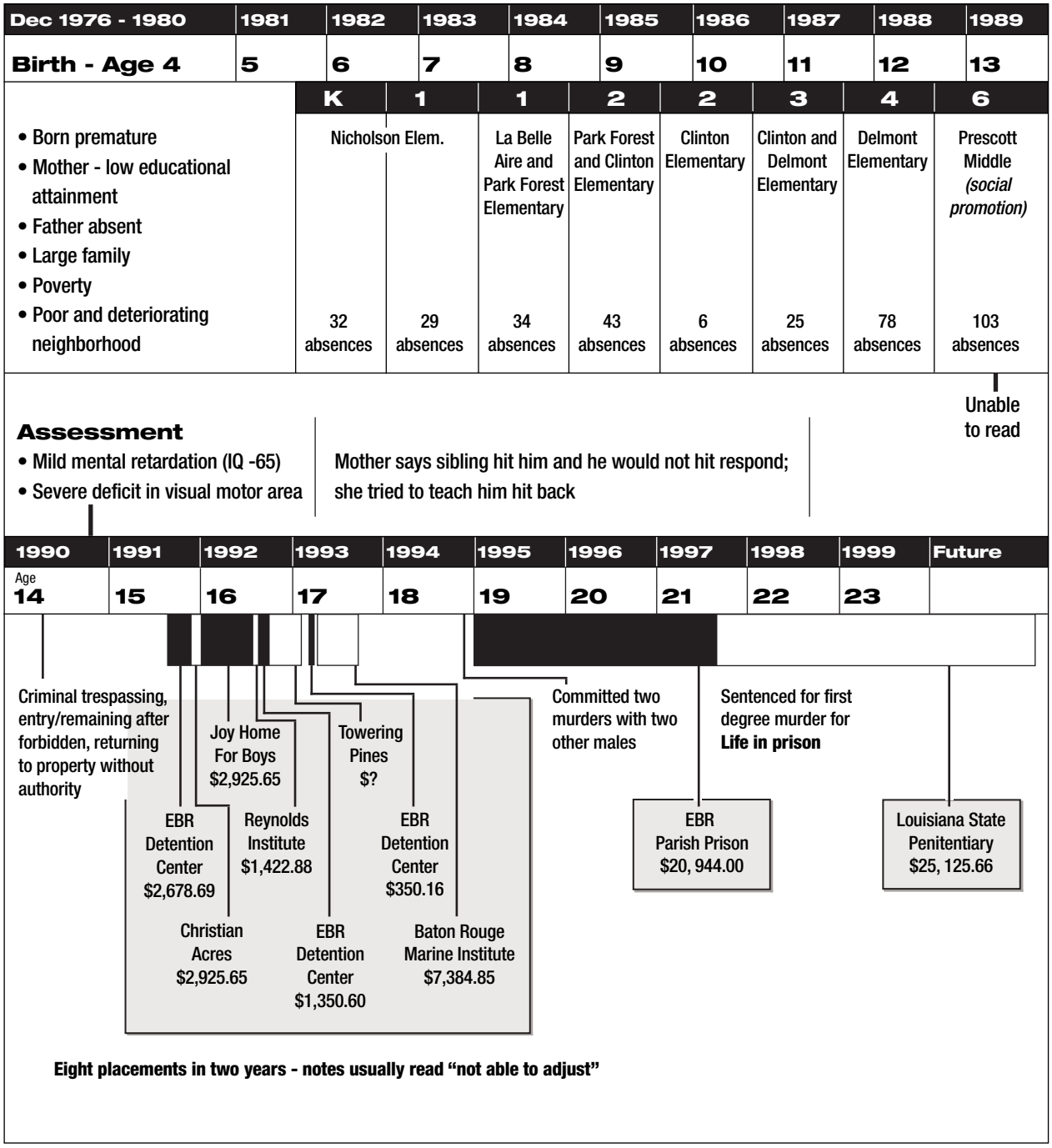
In closing, there are still some hard records and medical information being requested. Should additional information be obtained, this report will be revised accordingly.

Respectfully Submitted,

_____

Name and title of expert submitting report
Date of submission

Example of Timeline: Robby Life History



The report, with detailed documentation of records and life events is presented to the attorney for use in the client's defense. The social history, along with the psychological testing, in the case described above, provided clear evidence that this person suffers from mental retardation, which is not at all how the client presents himself.

Part B. Use of Expert Mental Health Witnesses, Mitigation and Sentencing Strategy

How Can Expert Mental Health Witnesses Help You?

The use of strategically selected experts and specialists can assist attorneys in numerous aspects of the legal defense, including:

- Communication style and the manner in which the attorney relates to the client
- Client's competence to stand trial
- Client's mental state at the time of the offense
- Plea negotiations
- Jury selection
- Making decisions about client testimony
- The need for medical treatment or other services for the client until the case is disposed
- Determination of assessments, evaluations and testing that is needed
- Selection of witnesses for the trial, including the penalty phase

How Can I Obtain the Services of an Expert?

This may be an iterative process, particularly when the case involves a misdemeanor or other offense with minimal sanctions. It is often suggested that an incremental approach to getting the client properly assessed or getting the attorney the help needed to most productively deal with the client is the best way to proceed. In other words, the attorney would begin the process of gathering basic data and approach the judge with factual information requesting support from an expert. Unfortunately, this type of incremental approach may not always be practical. Some judges may determine that a misdemeanor case does not warrant the use of an expert witness, as they believe that the defense counsel is only entitled to one expert per case. Additionally and more probable, judges may look upon the use of experts in minor cases as unnecessary and a waste of limited resources. This may also be true in some felony cases. Thus, it is incumbent upon the attorney to make the case for the use of an expert early in the legal procedures involving persons with mental disabilities.

It is almost always a good idea to consult with attorneys in the community about the process to get experts appointed in the case against persons with disabilities. There may be some standard form motions that have been successfully used. Also, remember that the Fair Defense Act provides for the reimbursement of reasonable and necessary expenses, including mental health experts. It is critical that attorneys make a record if they are unable to get permission to hire the experts or resources needed.

Types of Professionals to Consider for Information Gathering and Diagnostic Capability

When deciding who to obtain as a mental health expert(s), the attorney should consider first consulting a mitigation specialist, who will often be a licensed social worker. The specialist will:

- Conduct a thorough bio-psycho-social history investigation
- Interview the client
- Conduct collateral interviews
- Gather the client's medical records
- Determine what cultural, environmental, and genetic circumstances might have factored into the client's case

Mitigation specialists are superior in many cases to using traditional law enforcement type investigators in developing mitigating evidence because they have training in the human science and an appreciation for the variety of influences that may have affected the client's development and behavior. At any rate, the person conducting the investigation should have training, knowledge, and skill to detect the presence of factors such as:

- Mental disorders
- Neurological impairments
- Cognitive disabilities
- Physical, sexual, or psychological abuse
- Substance abuse
- Other influences on the development of the client's personality and behavior

Mitigation investigations should be thorough and extensive, especially in capital cases where the whole of the defendant's life needs to be judged in order to determine whether to spare him or her from execution. Moreover, the U.S. Supreme Court has held that failure to investigate such matters in a capital case could constitute ineffective assistance of counsel. See *Wiggins v. Smith*, 539 U.S. 510 (2003). On the other hand, if the client is charged with a misdemeanor, it may be enough to simply use the social worker mitigation expert, or another qualified investigator, as the only expert in the case.

Specific Types of Professionals:

Social Worker — Although there are three levels of credentialed social workers, the only level licensed to practice clinical social work independently is the Licensed Clinical Social Worker (LCSW). The LCSW holds a Master's degree in social work and has completed 5760 hours of postgraduate social work practice. Additionally, the LCSW has passed a qualifying examination. The LCSW is generally hired for mitigation work because the degree and credentials offer substantive evidence of intensive formal education and supervised clinical work prior to licensing.

The Registered Social Worker (RSW) and the Licensed Master's Social Worker (LMSW) are not qualified to practice independent clinical social work.

It is important to note that the MSW (Master's of Social Work) is considered a terminal degree in the field. The Doctor of Philosophy in Social Work (Ph.D.) or the Doctorate of Social Work (DSW) is generally pursued by social workers interested in academia, expert status or advanced clinical social work practice.

A forensic social worker is ideal to use in case history development because this social worker has been trained and is experienced in working with court related matters.

The mitigation expert may then confer with a consulting psychologist, who will review the records and have the ability to determine what kinds of expert witnesses may be needed and what roles experts are needed to fulfill. In some cases, a professional with specialized expertise in testing intellectual functioning is required. Other cases may require a specialist in personality testing, or someone trained in the area of sexual trauma to interview the client. The consulting psychologist will only refer specific aspects of the client's case to the testifying experts, who will interview the client in preparation for courtroom testimony. This is because of the specialized field within which most psychologists work.

Psychologist — Psychologists are usually *not* specifically trained in case history development or life history research. Psychologists generally study the human mind, including behavior and cognition. They may be specifically trained in assessment, diagnosis and treatment, but there are a variety of areas of specialty in psychology, i.e. industrial psychology, clinical psychology, school psychology. As

opposed to the licensed social worker that is specifically trained to work with a person in his/her environment, a licensed psychologist is trained to work more with the mental health diagnoses and treatment within an office or hospital setting.

Both social workers and psychologists are trained in developmental issues, but from different perspectives. Social workers may examine developmental history and determine how it has led to the current life situation of a client, e.g. child abuse and later violent behavior. A psychologist may look at developmental issues and determine how this has affected brain development and functioning and the effect this may have on behavior, e.g. child abuse and brain damage or developmental problems.

A doctorate (Ph.D., Psy.D., Ed.D.) in psychology is required for licensure in most states. A Master's Degree in Psychology does not generally warrant licensure by the American Psychological Association. A Master's level psychologist may obtain an LPC – a Licensed Professional Counselor – to obtain licensing for counseling. The main function that licensed psychologists provide in forensic cases is assessment, testing and diagnosis.

Psychiatrist — A psychiatrist is a physician with an earned MD (Doctor of Medicine) or DO (Doctor of Osteopathic Medicine). They may perform a brief assessment and treat clients pharmacologically, as opposed to psychologists, who conduct an in-depth assessment and provide psychological counseling. In forensic cases, it is most likely that the services of a licensed clinical or forensic psychologist and/or psychiatrist would be sought. If the attorney, social worker, mitigation specialists or other members of the defense team believe that the client is seriously impaired, the services of a neuropsychologist or neuropsychiatrist should be obtained.

Neuropsychologist/psychiatrist — The use of a neuropsychological expert is often crucial in explaining the specific disabilities that one may have. It is a specialty in the field of psychology that focuses upon the structure and function of the brain and how these relate to processing of information and behavior. They may conduct neuropsychological tests that isolate different operations of the brain, enabling a comparison between normal functioning versus functioning by a person with disabilities. These tests are particularly critical in the case of a client with mental retardation.

Neuropsychologists can also perform brain scans and related diagnostic tests to determine the extent of brain injury or brain activity.

Neuropsychiatry is an area of medicine dealing with the biopsychosocial treatment of disorders associated with brain dysfunction (Department of Psychiatry, Loyola University Health Systems, (http://www.stritch.luc.edu/depts/psych/). The field serves as the link between mind and matter as well between intention and function (Yudofsky & Hales, 2002). Specific to legal defense, attorneys will be interested in mental disorders attributable to diseases of the nervous system *and* how these disorders affect behavior. Neuropsychiatry is closely related to neurology, but both of these fields are important when diagnosing and attempting to explain the behavior of a person with disabilities, particularly mental retardation.

Research has clearly shown the link between neural correlates, e.g. frontal-subcortical circuitry and various psychiatric symptoms. Although this level of assessment may only be called for in the most serious legal cases, such as first or second degree murder, it is important for attorneys to be knowledgeable of this type of testing for persons with disabilities. However, it is important to note that a major contributor to the "cycling in and out of jail" problem is related to the fact that disorders are not diagnosed early, resulting in sanctions that the defendant with disabilities is incapable of following.

Mitigation Specialist — A mitigation specialist is most often hired in capital cases and other cases involving potentially lengthy jail time. The traditional role of the mitigation specialist has been to conduct an extensive life history investigation for the purpose of producing objective, reliable

information about a defendant's life, including any factors that might mitigate the circumstances of his/her behavior. This type of research often creates the opportunity for a more humane legal outcome, e.g. life instead of death, treatment instead of incarceration or alternative sentencing practices.

However, the use of a trained professional to develop a life history on a client with mental disabilities who is not facing a severe sentence should not be overlooked by attorneys or the courts. In many cases, an extensive case history report, particularly for young adult offenders, can provide the foundation for the client's entire future. If the legal system understands the effects of the disabilities on a chronic low level offender, it makes it much more likely that it can develop an effective pre-trial diversion or probation disposition, so that the client will avoid the "revolving door" of the court and jail. If the attorney can knowingly describe the disability and its effect on behavior, the court is much more likely to agree to a plan that will work for the client, as opposed to propelling the client into jail repeatedly until a long term sentence becomes necessary.

For example, if a client has a history of failing to get to court when scheduled, or failing to have a urinalysis when required, it would be important to know of the person's abilities to use money, tell time, negotiate public transportation or follow instructions. Oftentimes, the only way to differentiate a person with disabilities from a person who could care less about meeting probationary rules is to have psychological testing performed. Generally, the attorney or other helping professional will have some idea that the client may not be functioning at a very high level. This acknowledgement, combined with the inability to follow instructions and a history of failed attempts at meeting daily expectations, should lead the attorney to seek out a formal assessment process.

A mitigation specialist usually obtains and organizes the life history information so the attorney and/or court can see various patterns of behavior and how these are contributing to the current situation. For capital cases, the information is used to offer a rational explanation for the defendant's behavior. In non-capital cases, this type of research can link behavior with psychological, physiological or neurological roots.

Example: Matt's Chronology

3/21/80	• Mother diabetic • Client born by C-section 10 weeks premature but of normal weight • Initial Apgar: 6 out of 10; 5 minutes later: 8 out of 10 • Hypoglycemia • Bloody stools: Sepsis • Released after 19 days; mild respiratory distress syndrome
Childhood	• Absent father; no child support • Age 7 or 8: Fell out of car: Leg injury • Age 8: Emergency appendectomy
1983 - 1990	Mother's live-in boyfriend a father figure • Stable family structure
1984 - 1987	Kindergarten and 1st grade at high risk school: • Repeated 1st grade at mother's request: She felt he hadn't learned enough • Mom has trouble believing Matt's disability

1987 - 1988	2nd grade at different school • Grades: A's, B's C's, D's
1988 - 1990	3rd and 4th grades at another school • Grades: B's; On honor roll at one point • 3rd grade: Mother noticed facial seizures
1990 - 1992	5th and 6th grades at another school • Grades, attendance, and conduct dropped • Older brother shot and paralyzed; Client helped care for him • Client began "reaching out" for biological father • Age 11: Saw a private psychiatrist for bad temper • 6th grade: Suspended 3 times for fighting • Older sister left home to join Army
5/92	High Risk Junior High School – 7th grade • Grades: C's and D's and below average conduct grades
1993	• Began using marijuana • Began selling marijuana
10/93	• Matt found passed out on bathroom floor at home: Admitted to Hospital • Enrolled in another Junior High School
12/10/93	Client withdrawn from school
4/94	Client had severe seizure: Diagnosed with a seizure disorder
7/94	Summer school
8/18/94	8th grade: Junior High
10/7/94	Simple Battery of a police officer; Simple Battery of a school teacher
10/94 - 6/19/95	Juvenile Detention Center
3/4/95	A prison neurological exam recommended to rule out seizure disorder as a contributing factor to explosive outbursts
4/22/95	Public Hospital • Diagnosis of Seizure Disorder • Normal CAT Scan
5/17/95	• Normal EEG (while on medication) • Placed on Depakote 250 mg

1995	On probation for two years after release from Detention • Enrolled in Junior High: Ninth grade • Over 40 unexcused absences • Suspended 3 times • First experimented with cocaine • Smoked large amounts of marijuana "blunts" on weekend • Became best friends with H.T.: Sold drugs together
4/13/95 and 4/26/95	Possession, Manufacture, and Distribution of Drugs
1995	Unauthorized Use of a Movable/Illegal Possession of a Stolen Vehicle
8/4/95	• Court-ordered psychological evaluation by M.M., Ph.D. and D.H., Ph.D. (for assault of police officer) • Diagnosis: 1. Conduct Disorder, Non Specific, Severe 2. Seizure Disorder, Non Specified 3. R/O Neurological Factor Contributing to Periods of Episodic Dyscontrol
8/16/95	• In Detention (for assault of police officer) • Consulting prison psychiatrist: C.C., M.D. • Recommended placement in a residential treatment facility • Suggested that client continue seizure medications • Note: Probation officer is T.
9/14/95 - 10/13/95	• Detention, non-secure (for the vehicle charges) • Psychiatric evaluation
10/19/95 - 11/16/95	• Friend C.S. hanged himself: Traumatic loss • Began experiencing anhedonia, sleep disturbance, anxiety and depression
11/16/95 - 11/22/95	Juvenile Prison • Beaten for "not talking loud enough"
11/22/95 - 3/13/96	Juvenile Prison records • Aggressive, defiant behavior: Tickets for fighting and defiance • An episode of being beaten by numerous lieutenants • Eventually beaten "every time I talked" • 11/22/95: Placed on Depakote 250 mg • Psychiatrist: G.J., M.D.
1/9/96	Aggravated sex offense: Grabbed a friend while playing basketball
1/17/96	Not showing up for medicine call – Depakote discontinued

3/13/96 - 11/15/96	Move to private juvenile prison and placed in secure cell
4/96	Depakote resumed after another seizure
7/96	Not taking medicine – Giving it to other inmates
11/15/96 - 1/30/97	Private juvenile Prison: • Primary caseworker: L.T. • Secondary caseworker: J.R. • Restarted on Depakote 50 mg for seizures • Anger, agitation, behavioral dyscontrol • Father visited client and became actively involved • Exposed to violence: • Security guards beat up inmates • Witnessed a rape • All weekend: inmates allowed to fight with each other • Beaten by 6 guards who kicked and punched him: Ear injury with no medical treatment
3/23/96 - 4/6/97	When client returned home, he ran away
4/5/97	Client was 17 years old when he and H.T. were arrested for Armed Robbery and First Degree Murder of a clerk in a grocery
2/23/98 and 3/10/98	Psychiatrist S.F., M.D. evaluated client: • Borderline range of intellectual functioning (IQ=71) • Weakness in judgment, reasoning, visuospatial organization • Dysthymic Disorder • PTSD symptoms • High levels of anxiety In 1995-1996 met criteria for Adjustment Disorder with Mixed Disturbance of Emotion and Conduct
1/1/99	EEG (on no medication): Abnormal; indicated seizure disorder Restarted on Depakote
3/1/99	Switched from Depakote to Dilantin
3/1/99	Neurological Assessment by Medical Center: "Matt is an eighteen-year-old man who has a clinical history and neurophysiological (EEG) evidence for a seizure disorder. Seizures are paroxysmal events, which can manifest themselves in a spectrum. Seizures can present with only periods of outward confusion, disorientation and nothing else to events which consist of loss of consciousness and jerking movements of arms and legs."

Additional Information:

- Father and step-brother (father's son) are reported to also have a seizure disorder
- Four friends were killed by street violence or suicide since 1995 - the client has been robbed several times for money and shoes

The chronology of Matt's life was prepared by a licensed forensic social worker that was also trained in mitigation work. The chronology enables the attorney to easily understand the client's life path and assists the attorney in appropriate question formation.

Focus on Testifying Experts

Pay close attention to the testifying expert's qualifications, and select someone who will be the most credible and persuasive to the court and jury. It is important for testifying experts to be forensically trained since they will have a better understanding of the legal questions that need to be answered. It is important to thoroughly investigate the expert's background and prior testimony. It is good to have someone who has testified before and knows how to handle cross-examination. If the client's primary language is not English, it is advisable to consider hiring an expert who is fluent in the client's primary language. Testifying expert witnesses fall into several categories and should be selected based upon who can best meet the needs of the case:

- For testimony related to diagnosis, treatment, and medication for mental disorders and medical issues, the services of a psychiatrist should be obtained, preferably one with a forensic specialization, as the testifying expert witness
- For testimony related to personality or behavioral disorders, intellectual or cognitive functioning, administering and interpreting test, a psychologist should be obtained as the testifying witness
- If the client has a brain injury or has problems with memory, language, or orientation functions, the services of a neuropsychiatrist or a neuropsychologist may be obtained as the testifying witness

The attorney may also want to use a pharmacologist or a specialist in addition to medicine or in sexual trauma, if appropriate.

Local mental health professionals may not have the expertise needed in the case. Additionally, if any circumstances arise that are questionable relative to the objectivity of the local health professionals in question, seek expert assistance elsewhere. Many practitioners consider the incremental approach to developing mental health evidence superior to the "complete psychological evaluation" that attorneys often request, particularly in capital cases. Approaching a case incrementally may be more cost efficient and more likely to produce information that will advance the defense theory and support the client. Ideally, the same professional should not fill more than one role (evaluator, consultant, or prior treatment person, mitigation specialist, substantive expert).

Why is mitigation important?

Mitigation is not a defense to prosecution. It is not an excuse for committing the crime. It is not a reason the client should "get away with it." Instead, it is evidence of a disability or condition that invites compassion. Mitigation is the explanation of what influences converged in the years, days, minutes, and seconds leading up to the crime, how information was processed by a person with a mental disability, and the behavior that resulted.

Human beings can react punitively toward a person whom they regard as defective, deviant, or fundamentally different from themselves. A client's bizarre behavior or symptoms may be misunderstood by jurors or engender such fear that this behavior becomes an excuse to punish the defendant rather than a basis for mercy. Good mental health experts can provide testimony at the punishment phase to help the jury understand who the client is, how he or she experiences the world, and why the client behaves as he or she does. Well-selected experts can help humanize the client, enabling the judge and jury to see him/her as a person who deserves empathy and compassion. Many lives are spared in capital sentencing proceedings when jurors come to understand empathetically the disabilities, brain damage, and tormented psyche that may have led to a client's behavior. When presenting mitigation evidence, the relationship between the disability and the conduct must be clearly demonstrated. It is not the, "What?" it is the, "So what?" If the attorney cannot answer the "So what?" question that each juror will be asking, the evidence of disability will look like an excuse, not an explanation.

Sentencing Strategies

When thinking about sentencing of the client with mental disabilities, there are a number of things to be considered and weighed.

Mental health information as mitigation can sometimes hurt you. Carefully consider the decision to raise the client's mental disability to the jury. Some jurors do not believe in mental illness or related disabilities. Some jurors will not want the client to be out in the community on probation. The client's mental disability may become fair game for argument; the state may try to use it against the client. The prosecutor might say, "What's to keep this person from going off his medications again?" Or the prosecutor might suggest that, "We have to keep people with mental disabilities locked up for their own safety." On the other hand, it is essential to remember that failing to raise the issue of the client's mental disability may result in (1) a probated sentence that the client cannot comply with or (2) a period of incarceration that will further damage the client's mental health.

If you decide to raise your client's mental disability at the punishment or sentencing phase, be sure you have sufficient evidence and expert help. The attorney should also be able to say more than, "My client is depressed." He/she needs to talk about the extent of the depression. Was the client depressed for a short period or was it more serious? Unless it is a very serious case that can be substantiated, jurors may think, "We've all been depressed" or, "Everyone's depressed when they're in jail." Remember, the scope of the jury's inquiry at the punishment phase is much broader than at the guilt/innocence phase. There are different types of mental health experts, diagnoses, and resources that may be helpful. Simply interviewing the client or submitting him or her for a single mental health exam will almost always result in an incomplete picture.

You may be better off advising your client to waive a jury and taking the mental health evidence directly before the judge. The decision to go to the jury or the judge for sentencing depends on several things, including the charges involved, the judge, and the prosecutor's willingness to work with the defense. If the client decides to go to the judge for sentencing and the attorney is seeking probation, there should be a proposed program to provide supervision to help the client stay out of trouble. Good attorneys are advocates for their clients. Bring in witnesses who know the client, such as his or her psychiatrist, his or her caseworker and family members. If the client is on probation and the State has filed a motion to revoke or a motion to adjudicate guilt, the attorney should seek the above-mentioned sources to keep the judge from revoking the client's probation or entering a conviction on the record against the client and sending him or her to jail. The attorney can also have the probation officer handling the client's case testify about whether the client is on a specialized caseload.

Make sure your client receives an accurate and complete mental health evaluation. If the attorney is planning to bring the client's mental disability before the judge or jury for sentencing purposes, it is important to make sure that the experts being used do more than conduct a mental status examination and offer a

diagnosis. The attorney must work with the expert to ensure that he or she conducts a wider-ranging inquiry into the client's mental health history and its implications. For example, if the client suffered a head injury at an early age, causing brain damage, the expert must discuss this and the effect that it had on subsequent behavior. Or, if there is a family history of mental illness, disability or a generational pattern of violence and abuse in the home, the effects of growing up in this type of environment must be addressed. It is important to interview outside sources such as family members, former teachers, physicians, etc., as well as to request all available records. A comprehensive mental health examination should include:

- A thorough physical and neurological examination
- A complete psychiatric and mental status examination
- Diagnosis studies, including personality assessment
- Neuropsychological testing
- Appropriate brain scans
- A blood test or other genetic studies

In capital defense litigation, it is especially important to make sure the client has thorough and comprehensive mental examinations that evaluate each area of concern as indicated by the client's bio-psycho-social history.

Many offenders with disabilities have co-occurring substance abuse problems. Many persons with mental disabilities have addictions to drugs and/or alcohol; others "self-medicate" the symptoms of their mental disability with drugs or alcohol. Under either scenario, it is likely that this type of client will have problems staying clean and/or being successful on probation. Both substance abuse and mental illness are chronic, relapsing illnesses that need treatment. If the client has a substance abuse problem and also a serious illness, the attorney should look into the availability of dual diagnosis treatment programs in the local community. Some clients would rather accept a plea bargain agreement for jail time than wait to get into substance abuse or dual diagnosis treatment. The client must make the ultimate decision about whether to get the treatment, but the attorney must talk candidly with the client about it. An example might be: "Look, you have this problem and you're probably not going to make it on probation. You're going to end up in the penitentiary, but we can get you some treatment to help you avoid that." Talking to the client about doing what is best for him or her over the long term rather than the short term is the best and most ethical approach.

Your client's mental disability should be factored into decisions about probation. Remember that the client may not be able to hold down full time employment, pay probation fees, keep track of appointments, navigate public transportation, perform community service or complete schooling the way that other clients can. A client with disabilities may require special arrangements and extra help if these tasks are part of the client's sentence. If the client is being placed on probation, the attorney should work to assure that the client gets probation with treatment or gets conditions placed on his or her probation that will help him or her successfully complete it. If the client is facing revocation of his or her probation, the attorney should educate the court about the client's specific mental disability and the treatment options that could be made part of his or her probation.

Your client may not want treatment. The client cannot be forced to get treatment if he/she does not want it, even though it is quite clear that treatment is in his/her long-term interest. In this case, the attorney may be limited in what can be done for the client. If the client's charges are minor and he/she has a supportive family, has a safe place to live, is usually relatively stable and is competent, it may be better for him/her to plead to jail time if a good deal can be negotiated. However, the attorney is obligated to set out all the pros and cons of any plea bargain agreement for the client. If the client is considering straight jail time, the attorney should tell him/her the possible benefits of taking probation with a condition that requires treatment. The attorney should tell his/her client what he/she believes the

chances are of him/her staying out of trouble if he/she does not get treatment, and what penalties might await the client if he/she re-offends. It is always helpful and suggested that the attorney involve a concerned family member or friend to discuss these options with the client, as it is doubtful that many clients with disabilities will be able to understand the consequences of the various options.

Go the extra mile for your client. Persons with mental disabilities who are not linked with appropriate services at sentencing are likely to re-offend, perhaps with more serious consequences and penalties attached to the second or third arrest. Try to set up the client with ongoing treatment and services so that he/she will stay out of trouble. If the client is going to the penitentiary, the attorney should recommend that he/she be sent to a specialized mental health unit. If the client is being released on probation, stable housing is especially important. Talk with the probation department about the resources it uses. Call the local Mental Health Association, the local chapter of the National Alliance for the Mentally Ill (NAMI) or the local mental health authority for recommendations about services. Local mental health resources in Louisiana generally respond to requests for information from courts, judges, and attorneys, although this has become increasingly difficult in areas affected by Hurricanes Katrina and Rita.

Part C. FORMS

Client Interview Form

McRainey 2007

Client: _____

Facility: _____

Date: _____

Interviewer: _____

Interviewee: _____

1. When and where were you born?
2. Do you know anything about your mother's pregnancy or about your birth?
3. What kind of kid were you? Did you get in trouble a lot or did you stay out of trouble?
4. Who did you live with when you were growing up?
5. Who do you live with now?
6. Tell me about your parents and your siblings. What do they do?
7. How about the rest of your family – grandparents, cousins, aunts? Are they in good health? Do they have any problems?
8. Where did you go to school?
9. Did you repeat a grade?
10. Did you go to special education classes?
11. What is the highest grade you finished?
12. How was your behavior while you were in school?
13. Do you remember learning to read and write? Was it hard or easy?
14. How is your health? Do you take any medicine? Have you ever? Do you hear and see well?
15. Have you ever been in the hospital? Have you ever been in an accident or had a head injury?
16. Have you ever seen a psychiatrist or a psychologist? What did they tell you?
17. Have you ever had a job? What kind of job would you like to do?
18. Do you have a group of friends? What do they like to do for fun?
19. How is your mood? Are you usually happy or sad? Do you get angry easily or does it take a lot to get you upset?
20. Tell me three things about yourself that you are proud of.
21. Tell me three things about yourself that you wish you could change.

22. I am going to list some things and I want you to tell me if they are easy or hard for you to do:

- Looking up a phone number
- Writing a check
- Shopping for groceries
- Making change
- Telling time on a clock with hands
- Naming the days of the week
- Paying attention to what people are saying
- Reading a bus schedule
- Following a recipe
- Understanding what people are saying
- Reading
- Washing clothes
- Learning new phone numbers

Family Interview Form

McRainey 2007

Client: _____

Facility: _____

Date: _____

Interviewer: _____

Interviewee: _____

1. How are you related to my client?
2. What can you tell me about the pregnancy? Was there prenatal care? Did his mother use drugs, alcohol or cigarettes? Was there any illness or accident?
3. Was he a term birth? How much did he weigh? How long was he in the hospital?
4. Are there any family members with mental retardation or mental illness? Did his parents and siblings graduate from high school? What do they do now?
5. Did he meet his developmental milestones on time?

Walking?	_____	8-16 months
Talking?	_____	12-24 months
Toilet Training?	_____	24-36 months

6. How was his school experience? Has he ever repeated a grade?
7. Was he in special education? What kind of class?
8. What kinds of grades did he make? What did his teachers say about him?

9. Did he have trouble learning to read or write?

10. Did he graduate?

11. Has he ever had a job?

12. I am going to list some things, and I want you to tell me if they are easy or hard for him to do:

    - Looking up a phone number
    - Writing a check
    - Shopping for groceries
    - Making change
    - Telling time on a clock with hands
    - Naming the days of the week
    - Paying attention to what people are saying
    - Reading a bus schedule
    - Following a recipe
    - Understanding what people are saying
    - Reading
    - Washing clothes
    - Learning new phone numbers

Comprehensive Forensic Interview Protocol

Guin 2007

Social Factors

Age:	What is your date of birth?
Gender:	This is assumed knowledge based upon appearance and records.
Race:	What is your race?
Urban/Rural:	What is your parish of birth? Parishes lived in growing up?

Health

(Some of the questions must be asked of adults/parents who were involved with the client during his/her childhood.)

Birth: What were the conditions of the client's birth? Any in utero or birth trauma? Where were you born so we can see if there are any birth records available? Rank order in children born in family? What was the health of the mother? Was the mother using alcohol, tobacco or drugs? Was the mother involved in domestic violence? Had the mother had any other problem pregnancies or miscarriages?

Injury:

Did you experience any type of injury while growing up? What type of injury?
Were you treated by a physician or hospital? Which physician or hospital? Have there been any residual effects from the injury? What records or secondary data exist to substantiate an injury and its effects?

Illness:

What types of illnesses have you experienced? Did you experience any type of injury while growing up? Get details and find out if medical records exist. Were you treated by a physician or hospital? Which physician or hospital? Have there been any residual effects from the illness? What records or secondary data exist to substantiate an illness and its effects?

Disability:

Do you have any disabilities (mental, physical, educational, etc.)? How did you become disabled, or is this a disability from birth? Is the disability substantiated or alluded to in school or vocational records? How has the disability affected you over time? Do others in the family history have the same disabilities?

Mental Health:

Do you have any history of mental illness? Have you ever been to a mental health counselor or mental health facility? Is there an indication of the mental health problem in school, from behavior in the family, from other agencies or organizations, the neighborhood, any law enforcement or correctional agencies? What do the hard records indicate about the client's mental health? Are there other family members, current and intergenerational, with a history of mental illness?

Substance Abuse/Use:

Have you ever used alcohol, tobacco and or other drugs (ATOD)? If so, what quantities were used throughout each phase of life? How old were you when you began use of ATOD? Did family members use ATOD? Who used, what did they use and how long did they use? What is the intergenerational use of ATOD? Have you or anyone in the family been treated for ATOD through counseling or residential care? Have you or anyone else in the family been involved with alcohol or drug related driving offenses?

Education

School Attendance:

What schools have you attended beginning with pre-K? What grades did you attend at each school?

School Performance/Grade Attainment:

Were there any grades that you failed or were held back? How did you perform in school? What were your grades like? What was your favorite subject? What subject did you like the least? Were you ever in trouble at school? What types of things did you get in trouble for? Were your parents contacted when you got into trouble? Did they meet with the teacher? What did your parents do if you got into trouble at school?

Truancy:

What was your attendance like? When you missed school, what was the reason? Did you drop out of school? If so, when did you decide to do this and why?

Disabilities:

Were you ever in special education? Do you know why? Did you have any trouble learning? Do you recall if the teacher or counselor ever talked to you about any type of learning or educational problem that you had? Has anyone ever talked to you about being retarded or slow? Did your family ever talk to you about this?

Family Related Education:

How far in school did other people in your family go? Do you know if your Mom and/or Dad received a high school diploma? Did any of your brothers or sisters? Has anyone in your home attended college or gradated from college? Do you know if any of your brothers or sisters had any problems in school? What types of problems did they have? Do you remember anyone talking to you about any of your brothers or sisters being slow? Were any of your brothers or sisters ever suspended or did you know of any behavior problems they had in school?

Can you tell me how much education your grandparents have or other extended family, like your aunt or cousin?

Do you remember if anyone in your extended family was ever described as slow or retarded?

Family

Structure:

Did you grow up with your mother and father in the house? If not, who was "in charge" at your house? Where are your parents now? What are their names? Did you have any step-parents or other adults living in the house? How many brothers and sisters do you have? Do you know each one's name, birthday and current location? Do you have any half sisters or brothers or other family members that you are related to through marriage or other relationships your Mom or Dad had? Did anyone else like your grandmother or aunt live with you?

Living Arrangements:

How many people lived in your house as you grew up? How many bedrooms were there? Who stayed in what rooms? Did you move around a lot? How many homes would you say you lived in growing up?

Child Maltreatment/Violence:

Were you and your brothers or sisters at home without adult supervision a lot? What did you do when you were at home without your parents?

How did everyone in your family get along?

Did your Mom and Dad (or step-parents/live-ins) argue much? What types of things would they argue about? Do you recall if your parents ever hit each other? What types of situations would cause a fight between your parents? What did you and the other children do when your parents were fighting? Did your parents ever cause physical damage to one another when they were fighting? Do you know if either one of your parents ever had to go to the doctor or hospital because of their arguments or fights?

What would your parents do if you ever got into trouble?

How did your Mom and/or Dad discipline you if you were bad? Did they ever hit you? If they did, what did they hit you with? Did your parents ever hit any of your brothers or sisters? Can you recall a story to tell me so I can understand what it was like to be in trouble at your house when you were growing up? Do you remember if the police were ever called to your house because of physical fighting or whippings? Tell me about that.

Do you remember if anyone from the state ever came to your house to talk to you about spankings or whippings? Did anyone ever come to your house and ask you if you had enough to eat or ask you about your clothes?

Poverty:

Do you remember having enough food when you were growing up? Do you ever remember going hungry? Did you have as much or more things as the other kids at school?

Was the home you lived in about the same as the other kids' homes? Did you feel that other kids' homes were as nice as yours, nicer than yours or about the same?

Do you know if your parents made enough money to support your family with all of its needs? Did your parents work? What type of work did your Mom and/or your Dad do?

Was there ever a time that you did not have a phone or electricity?

Do you remember if you were ever ashamed of where you lived or how you dressed?

Do you remember if your family received any type of "check" from the government? Do you recall if your family used "food stamps" to buy groceries?

Do you recall if your other family members, like your aunt or grandmother, had a lot of money? Did anyone share any money with you or your family?

Did you work when you were old enough, but still living at home? How old were you when you had your first job? What did you do with your money?

Economic

Income:

Try to determine income level from parents at the time client was growing up by talking with persons who were adults when client was in childhood.

Do you know if there were other sources of income in your family when you were growing up? Request records of government assistance programs if applicable. Do you recall being on the free or reduced lunch program in your school?

Employment:

Who worked in your family to support you and your brothers and sisters? Do you know what type of work your parents did? Did you begin working when you lived at home? What type of work did you do? How much money did you make? What did you do with the money you earned?

Illegal Gain:

Try to determine from client and others if income was derived from illegal sources such as drug distribution.

Neighborhood

Poverty:

Obtain addresses of client and become familiar with area in which he/she grew up. Formulate opinion on class level of neighborhood through direct observation, attainment of census data (housing, unemployment, condition of homes). Obtain photos for inclusion in testimony, if appropriate.

Homelessness:

Determine if client and family were homeless at anytime and try to determine where they

lived when without a home? Do you ever recall being without a place to live? Tell me about your experiences.

Availability of Guns:

Did anyone in your home own a gun when you were growing up? Where was it kept? Did you ever see anyone use the gun? Was anyone ever shot in your home?
Do you know if there were many guns in your neighborhood? Did you see people carrying or using guns? What would most people use their guns for?

Crime and Violence:

Were you aware of crime that took place in your neighborhood? What type of crime was most common? Do you recall being afraid in your neighborhood? What would make you scared when you were growing up?
Do you recall ever seeing any gangs in your neighborhood? Tell me about your experience with gangs while growing up.
Were you around much violence in your neighborhood while growing up? When I say violence, I mean things like people shooting guns at people, people being afraid to be outside, gangs threatening people, drug dealers threatening people in the neighborhood.

Criminological:

Number of Priors:

Have you been arrested before? How many times have you been in contact with the law? Would you tell me of each incident with law enforcement, both as a juvenile and after you were 17 years old?

Family History:

Do you know if anyone else in your family has been in trouble with the law? Who and for what? Has anyone ever been in jail or prison? Can you tell me the types of crimes that anyone in your family have been involved in or sent to prison for?

Age at First Contact:

How old were you when you first became involved with the law? How old were you when you were first arrested?

Detention/Incarceration:

Have you ever been in jail or in prison? Could you tell me when and for what? How old? Where you when you were first placed in a lock-up facility? Have you ever been in the LTI system? If so, when were you in one of those facilities and which one were you in? Could you tell me how you were treated if incarcerated as a juvenile?

Loss:

Death due to violent crime:

Are you aware of anyone in your family or neighborhood who died as a result of violence or as a result of a crime? Can you tell me who and what the circumstances were? How old were you at the time?

Incarceration:

Were either of your parents or any of the other adults responsible for you in jail or prison when you were growing up? How old were you? Who was in prison and for how long? Do you know what they did? Did you go visit your parents or other relatives in jail or prison when you were growing up? Can you tell me about this?

Institutionalization:

Were either of your parents or any of the other adults responsible for you placed in an institution, such as a mental hospital, when you were growing up? How old were you? Who was in the institution and for how long? Do you know why they were there? Did you go visit your parents or other relatives in the institution when you were growing up? Can you tell me about this?

Absent Biological Parent:

Were both of your parents present when you were growing up? If not, do you know where the missing parent was? Did you know both your Mom and your Dad? If not, where did you think they were? What did anyone tell you about your missing parent? Did you ever wonder why you did not have two parents present in the home? Did most of your friends or neighborhood children have two parents in the home? What effect do you think there might have been on you if you did not grow up with both parents in your life?

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Section 2:
Competency to Stand Trial

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Part A. Competency to Stand Trial

Competency Questions and Answers

What:

Q: What is competence?

A: A defendant is competent if **"he has sufficient present ability to consult with his lawyer with a reasonable degree of rational understanding – and [if] he has a rational as well as factual understanding of the proceedings against him."** *Dusky v. United States* **362 U.S. 402, 402 (1960).**

The Louisiana statutory formulation is found in La. Code Crim. P. art. 641: "Mental incapacity to proceed exists when, as a result of mental disease or defect, a defendant presently lacks the capacity to understand the proceedings against him or to assist in his defense." In the most simplistic terms: **Competence = communication + comprehension**

***Note*:** "Competence to stand trial" is used interchangeably with: "adjudicative competence," "competence to proceed," and "fitness to stand trial."

In 1994, the ABA's Criminal Justice Mental Health Standards stated that competence to stand trial is the single most important issue in criminal mental health. Studies estimate 50,000-60,000 evaluations a year.

Q: Is *Competency to Stand Trial* the same as *Not Guilty by Reason of Insanity (NGBRI)*?

A: No.

Competency to Stand Trial	Not Guilty by Reason of Insanity
The focus: The defendant's mental state precludes a fair trial. *Relevant time frame*: The time of the court proceedings.	*The focus*: The defendant's mental state precludes criminal responsibility, –i.e., does defendant know the difference between right and wrong? *Relevant time frame*: The time the offense was committed.

A defendant who has a NGBRI defense may be competent to stand trial. A defendant who is incompetent to stand trial may not have an NGBRI claim. The two concepts are distinct. Of course, if competence is an issue, then an NGBRI defense must be evaluated, and the converse is true as well.

Q: Is competence to stand trial different than competence to plead guilty or competence to waive right to counsel?

A: No, the two part *Dusky* test applies to competency across the board. *Godinez v. Moran*, 509 U.S. 389, 399 (1993). ("[W]e reject the notion that competency to plead guilty or to waive the right to counsel must be measured by a standard that is higher than (or even different from) the Dusky standard".) *Id.* This means that in theory if your client is competent to stand trial then he is competent to waive counsel and proceed *pro se*. The U.S. Supreme Court held in *Indiana v. Edwards* that a state *can* modify the mental standard required for a defendant to be able to represent himself without violating the Sixth Amendment. 554 U.S. 164 (2008). Recently, in *State v. Bell*, the Louisiana Supreme Court found that *Edwards* authorized but does not mandate states to require a higher standard of competence for the purpose of self-representation. – So.3d –, 2010 WL 4843890 *7 (La. 2010).

Q: If my client is mentally retarded is he incompetent to stand trial?

A: Not necessarily. Simply being mentally retarded is not alone sufficient to find a defendant incompetent to stand trial.

Mental retardation, as defined in DSM-IV TR, includes:
IQ of approximately 70 or below Deficits or impairments in at least 2 areas of present adaptive functioning Onset before age 18

Note: The DSM- IV TR refers to the Diagnostic and Statistical Manual of Mental Disorders. The subsequent edition, DSM-V, may be released sometime in 2011/2012, which may change the data contained in this section.

Q: If my client is mentally ill, is he incompetent to stand trial?

A: Not necessarily. Simply being mentally ill is not alone sufficient to find a defendant incompetent to stand trial.

Q: Is competency required for extradition?

A: Arguably yes, see *In re Hinnant*, 424 Mass. 900, 678 N.E. 2d 1314 (1997). But for a different outcome, see *Oliver v. Barrett*, 269 Ga. 512, 500 S.E. 2d 908 (1998).

Q: What if my client cannot remember anything that happened?

A: La. Code Crim. P. art. 645 (A)(2) says "The fact that the defendant claims to be unable to remember the time period surrounding the alleged offense shall not, by itself, bar a finding of competency if the defendant otherwise understands the charges against him and can assist in his defense."

Who:

Q: Who *can* raise the issue of competence? Who *must* raise the issue of competence?

A: The judge, defense attorney or prosecutor ***can*** raise the issue of competence. La. Code Crim. P. 642.

The judge ***must*** raise competency if he has reason to doubt the defendant is competent to proceed. When the judge has reason to believe that a defendant may not be competent to stand trial he has an obligation to raise, investigate and resolve the issue. This obligation is based on the judge's obligation to ensure that court proceedings over which he presides are consistent with due process; accordingly, this obligation exists regardless of the defense attorney's action or inaction relating to competency of the defendant. See *Pate v. Robinson*, 383 U.S. 375 (1966).

When:

Q: When should competency be raised? Can it be raised more than once?

A: Competence may be raised ***at any time***, e.g. pre-trial, during trial, or prior to sentencing. It may be raised again, even after it has been resolved in favor of competency, if the defendant's behavior or other circumstances suggest that there is reason to doubt his competence. See La. Code Crim. P. art. 642. If a trial is underway, there are 3 factors the court must consider when determining whether there is reasonable cause to conduct a competency hearing: (1) history of irrational behavior, (2) defendant's demeanor in court, and (3) any prior medical opinion on competency. *United States v. Ruston*, 565 F.3d 892, 902 (5th Cir. 2009).

Note: There are a number of psychiatric illnesses, such as schizophrenia and bipolar disorder, which are characterized by cycles during which the sufferer sometimes exhibits symptoms and sometimes the symptoms are in remission. Your client may be reasonably well one week and then very ill the next.

Practice Point:

Keep in mind that raising competence tolls the clock for prescriptive purposes of La. Code Crim. P. art. 572. See La. Code Crim. P. art. 575 (2).

Q: When, *ethically speaking,* should competency be raised?

A: If your client does not want the issue of his competency raised, this may create a conflict between your obligation to represent your client zealously and your obligation to ensure that your client's due process rights are protected. Arguably, if in fact your client is incompetent to stand trial, then he is incompetent to waive his due process rights. This is the reasoning the court used in *People v. Harris,* 14 Cal. App. 4th 984, 994, 18 Cal. Rptr. 2d 92, 98 (1993), to conclude that defense counsel does not provide ineffective assistance of counsel by seeking to prove his client's incompetence over his objection.

The American Bar Association, in the Criminal Justice Section Standards, states, "defense counsel should move for evaluation of the defendant's competence to stand trial whenever the defense counsel has a good faith doubt as to the defendant's competence. If the client objects to such a motion being made, counsel may move for evaluation over the client's objection. In any event, counsel should make known to the court and to the prosecutor those facts known to counsel which raise the good faith doubt of competence." ABA Standard for Criminal Justice 7-4.2(c).

Why:

Q: Why is it important for the defendant to be competent to stand trial?

A: Due process requires that a person be competent before being subject to criminal proceedings. *Drope v. Missouri,* 420 U.S. 162, 172 (1975).

Historical and Philosophical Underpinnings to the 'Competency to Stand Trial' Doctrine

As far back as the 18th century the English courts have referenced the unfairness of subjecting a mentally ill person to a trial. "That no man shall be called upon to make his defense at a time when his mind is in that situation as not to appear capable of so doing." Frith's Case, 22 How. St. Tr. 307, 311 (1790).

In the 19th century, American courts adopted the English prohibition against trying an incompetent criminal defendant. "It is fundamental that an insane person can neither plead to an arraignment, be subjected to a trial or after trial, receive judgment or after judgment, undergo punishment … It is not 'due process of law' to subject an insane person to trial upon an indictment involving liberty or life." *Youtsey v. United States*, 97 F. 937, 940-41 (6th Cir. 1899).

In addition to the due process implications, courts have based their reasoning on the threat to the accuracy of the court proceedings, as well as to the dignity of the court, that would result if an incompetent defendant is compelled to trial.

Procedures after Competency has been Raised

Appointment of the Sanity Commission – La. Code Crim. P. art. 644

The Appointment of a Sanity Commission is Within the Discretion of the Court - "[T]he appointment of a sanity commission is not a perfunctory matter, a ministerial duty of the trial court, or a matter of right. (Internal citations omitted). It is not guaranteed to every defendant in every case, but is one of those matters committed to the sound discretion of the court." *State v. Carmouche*, 872 So.2d 1020, 1042, (La.,2002), (citing, *State v. Martin*, 769 So.2d 1168, 1169 (La. 2000); *State v. Nix,* 327 So.2d 301, 323 (La.1975)). See also, *State v. Hicks,* 286 So.2d 331, 333 (La. 1973). (Where trial court did not abuse its discretion in denying application to appoint a Sanity Commission, when defense counsel only presented oral argument at the appointment hearing which reiterated points from the application for a Sanity Commission and failed to introduce any evidence for support).

Practice Point:

In order to persuade the judge that reasonable grounds exist to appoint a Sanity Commission, you should provide specific, credible evidence which supports the concern that your client is unable to communicate and assist in preparing a defense or that he is unable to understand the proceedings. (For definition of reasonable grounds, *see State v. Snyder,* 750 So.2d 832, 851 (La. 1999), (quoting *Lokos v. Capps,* 625 F.2d 1258, 1261 (5th Cir.1980)). This evidence may take the form of an affidavit or testimony - yours, jail staff, an expert or any other person who would have information relevant to your client's current mental state. You may also want to present medical records or other documentation establishing the nature and extent of your client's mental illness. However, remember that being mentally ill or mentally retarded alone is not sufficient to warrant the appointment of a Sanity Commission, there must be some evidence about your client's *present* mental state. It may also be helpful to remind the judge that although the appointment of a Sanity Commission is within the discretion of the court, if a reviewing court believes that there was substantial evidence to believe that your client was incompetent to stand trial and that the trial court abused its discretion in failing to appoint a Sanity Commission, then any subsequent verdict must be vacated. *State v. Henson*, 351 So. 2d 1169 (1977).

Note: The judge may try to question your client directly in order to assess the legitimacy of your request for a Sanity Commission. You should be very wary of allowing this to occur as your client may make incriminatory statements when speaking with the judge. If you provide the judge with affirmative evidence in support of the appointment of a Sanity Commission you can try to avoid this dangerous scenario. If the judge proceeds to engage your client in a conversation despite your presentation of evidence you can intervene and inform the court that you are advising your client against responding to the court.

Timing of Sanity Commission appointment - If the judge determines that there are *reasonable grounds* to believe that the defendant is incompetent, then he must order a mental examination of the defendant. Within seven days of this order the judge must appoint a Sanity Commission.

Composition of the Sanity Commission - The Sanity Commission shall have two or three members. The members must be physicians who have actually practiced medicine in Louisiana and have practiced for at least the three consecutive and preceding years. One member may be a clinical psychologist licensed in Louisiana, also with three consecutive and preceding years of practice, with training or experience in forensic evaluations. One member of the Commission must be a psychiatrist or, if a psychiatrist is not

reasonably available, a psychologist; and no more than one member may be the coroner or one of his deputies. La. Code Crim. P. art. 644(A).

Difference between Psychiatrists and Psychologists

Psychiatrist: A Medical Doctor with a specialization in Psychiatry; can prescribe medication

Psychologist: Ph.D. in Psychology; usually cannot prescribe medication; usually does psychological testing and therapy

Mental health unit team in lieu of Sanity Commission - In a judicial district that has entered into an arrangement for evaluation services with a local mental health unit (which has been legislatively created by the Human Services Authority), the mental health unit team may evaluate and report on the defendant's mental state in lieu of a sanity commission. La. Code Crim. P. art. 644(D)(1).

***Note*:** The defendant OR the state has the right to an independent examination by a mental health professional, in addition to that conducted by the sanity commission. La. Code Crim. P. art. 646.

Practice Point:

If the state intends to examine your client, you should insist on being present during the examination (1) to preclude both the state's expert from inquiring about the facts of the case and (2) to intervene should your client initiate a discussion of the facts of the case.

Handling the Experts: What you need to know to determine if an expert is qualified, if his/her testimony is valid, and how to challenge an expert's conclusions

It is critical to prepare yourself to handle the experts. The following questions and answers provide a foundation in the basics of understanding experts:

Q: How are experts trained?

A: Experts should have formal training in conducting competency evaluations. It is important to question an expert's qualifications, looking specifically at the type of training he/she has received in competency to stand trial assessment. Often, self-proclaimed competency experts have no formal training in the procedure, especially if they were licensed more than 20 years ago.

Q: How can I assess the significance of the expert's training and professional affiliations?

A: Look for psychologists certified by the American Board of Professional Psychology (ABPP) in their field of specialty, as they have met high standards for years of practice, types of training, and recommendations from people in the field. Psychiatrists can be similarly certified by the American Board of Psychiatry and Neurology, or the American Academy of Psychiatry and Law, which ensures credentials of forensic psychiatrists.

Q: Where do I find the standards that apply to their work?

A: The following have standards for the evaluations and opinions of psychologists, psychiatrists, and forensic psychiatrists: *The Ethical Principles of Psychologists and Code of Conduct*, *Principles of Medical Ethics with Annotations Especially Applicable to Psychiatry, Ethical Guidelines for the Practice of Forensic Psychiatry.*

Q: How do I prepare to present an expert's opinion?

A: To present an expert's opinion, it can be helpful to prepare a packet of information for the experts with relevant statutes, case law, assessment standards and literature. This will give your expert a solid foundation for their competency opinion. Of course, you should be mindful that any information which you provide to an expert, and which he uses to form his opinion, will be discoverable by the state.

Q: How do I challenge an expert's opinion?

A: If you disagree with an expert's opinion or think he/she is unqualified to assess your client, you can challenge his/her credentials, training, knowledge of the field (i.e. knowledge of current case law), or method of assessment. Evaluations based solely on a clinical interview, without formal testing, are easier to challenge because conclusions reached this way are a matter of one expert's opinion. The most important thing to remember is you don't have to accept the "experts" as such. You can challenge their expert status or opinions. You can also challenge an expert's method of assessment or testing under *Daubert v. Merrell Dow Pharmaceuticals, Inc.*, 509 U.S. 579 (1993), which is discussed in more depth below.

To challenge an expert's opinion, you may cite the American Academy of Psychiatry and the Law (AAPL), which recommends that experts discuss specific functional deficits of the defendant rather than just giving conclusions on the ultimate issue. The AAPL recommends including psychiatric diagnoses in forensic reports, as well as providing specific examples to show the defendant's strengths and weaknesses in reasoning and understanding. It is also recommended that reports do not discuss other legal matters, such as future dangerousness or lack of remorse, unless case law or statutes require comments on such matters.

Overview of Psychiatric Diagnosis from the Diagnostic and Statistical Manual- IV

Note: The DSM- IV TR refers to the Diagnostic and Statistical Manual of Mental Disorders. The subsequent edition, DSM-V, may be released sometime in 2011/2012, which may change the data contained in this section.

Axis I: Psychiatric Disorder Categories
- Thought Disorders (Schizphrenia, Schizpreniform, Schizoaffective, Brief Psychotic Disorder, Delusion)
- Mood Disorders (Depression, Mania, Dysthymia, Bipolar)
- Anxiety Disorder (GAD, Panic, OCD, social/specific phobia, PTSD, acute stress)
- Eating Disorders
- Impulse Control Disorders
- Substance Disorders (Intoxication, Dependence, Abuse)
- Amnestic Disorders
- Dissociative Disorders
- Behavioral Disorders
- Developmental Disorders
- Somatoform Disorders
- Malingering

Axis II: Mental Retardation (IQ < 70) and Personality Disorders

Axis III: Medical Issues pertinent to Axis I

Axis IV: Psychosocial issues
- Legal, homelessness, involuntary treatment, poor use of resources, lost job, lost custody of child, etc.

Axis V: GAF
- A number from 1-100; if 55 or greater, then the person is usually considered psychiatrically stable

Remember: Just because your client has a mental illness, does not mean he is incompetent for trial. However, it may help your case if there is a history of mental illness.

Practice Point:

Information from a client or medical records of your client's prescription medication may help you in evaluating what mental illness he may have.

Some Common Psychiatric Medications:

- **Typical Antipsychotics (Old)**
  Haldol (most potent), Thorazine, Mellaril, Navane, Prolixin

- **Atypical Antipsychotics (Newer)**
  Geodon (Ziprasidone), Abilify (Aripiprazile), Seroquel (Quetiapine), Risperdol (Risperidone), Zyprexa (Olanzapine), Clozaril (Clozapine), Saphris (Asenapine), Fanapt (Ilperidone)

- **Antidepressants** (sometimes used to treat anxiety and eating disorders as well)
  - **SSRIs**: Prozac, Zoloft, Celexa, Lexapro, Luvox, Paxil, Effexor, Cymbalta
  - **Others:** Elavil (also used for sleep or nerve pain), Buproprion (Wellbutrin), Trazadone (also used for sleep), Remeron (also used for sleep), Phenelzine, Pranylcypromine, Isocarboxazid

- **Mood Stabilizers** (For Bipolar disorder, also used to augment medications in depression and psychosis)
  Lithium, Valproic Acid (Depakote), Carbamazepine (Tegratol), Oxbarbazapine (Trileptal), Gabapntin (Neurontin), Lamotrigine (Lamictal), Topiramate (Topomax)

- **Anti-anxiety**
  Benzodiazapenes: Xanax, Librium, Nlonipin, Ativan
  Non-Benzo: Buspar

- **Dementia**
  Namenda, Aricept

Part B. The Competency Examination

The Competency Examination Introduction:

Preparing your client for the competency examination - Explain to your client in advance that the doctors are going to come to speak to him/her. That they will be asking him/her questions and that he should cooperate with them.[1] Explain that if he does not understand their question he should tell them so and not try to answer it. Explain that his conversation with the doctors will not be confidential; depending on your client's impairment you may need to explain what confidentiality means. You should explain why the doctors are coming to speak to him and that they will be both writing a report and possibly testifying about their meeting with him. You should also explain the possible outcomes – that if he is found competent his trial will go forward; if he is found to be incompetent he will go to the hospital.

You should consider being present during the examination – Your presence during the examination will assist you during the direct or cross-examination of the expert. It may also provide the expert with an opportunity to observe the attorney-client relationship. If you, your client or the expert are concerned about the effect of your presence on your client, then you can volunteer to sit away from your client and the expert and to remain silent during the exam. Alternatively, you can request to videotape or audiotape the interview.

No constitutional right to have counsel present at competency examination – *Buchanan v. Kentucky*, 483 U.S. 402, 424-25 (1987). In Buchanan, the Court held that a defendant's Sixth Amendment right to consultation is fulfilled so long as counsel is, "informed about the scope and nature of the proceedings" and is aware, "of the possible uses to which petitioner's statements in the proceeding could be put."

Statements that your client makes during a competency examination may not be used at trial unless he was *Mirandized* – *Estelle v. Smith*, 451 U.S. 454, 469 (1981). In *Buchanan v. Kentucky*, 483 U.S. 402, 422-23 (1987), the Court limited *Estelle v. Smith* to situations in which the defendant did not initiate the psychiatric examination or attempt to introduce psychiatric evidence at trial. *Not*e: In *Holmes v. King*, 709 F.2d 965, 968 (5th Cir. 1983) the court said that the defendant's Fifth Amendment rights were not implicated when he was compelled to testify at his own competency hearing because his statements were not used at trial.

Providing the Sanity Commission or other expert with background information – It may be helpful to provide the doctors with information about the background of your client. You can do this by supplying them with your client's school records, including discipline records, medical and psychiatric records, military records or disability records. Of course, it is essential that you carefully review these records prior to providing them to the doctors to ensure that there is nothing in them that might be harmful to your client. Remember that the doctors may make them part of his report and thus part of the court record; this in turn would make them available to the state if your client does proceed to trial. In addition to records, you may want to arrange for persons who know or knew your client to speak or write to the doctors describing their experiences with the defendant. You should consider family members, teachers or other school personnel, sports coaches, mentors and clergy. Again the same caution applies; you should preview the statements and/or letters that you arrange for the doctors to hear and/or see.

1. A trial court may find a defendant is competent to stand trial when the defendant refuses to cooperate with physicians trying to perform a competency hearing. *State v. Holmes*, 393 So.2d 670 (La. 1981).

Note: Louisiana courts interpret La. Code Evid. 1101 (B)(8) as not requiring the hearsay rule be applied at a competency hearing, despite the official comment suggestion that hearsay evidence is inadmissible at such hearings. *State v. Turner*, 13 So. 3d 695, 703 (La. App. 5th Cir. 2009), citing *State v. Castleberry*, 758 So. 2d 749, 758 (La. 1999).

Tools Used in Forensic Psychiatry to Evaluate Competency

There are a number of assessment tools or instruments that may be used by a forensic psychiatrist/psychologist in assessing your client's competency to stand trial. Below are some of the most common:

1. Competency to Stand Trial Screening Test (CST)

This is a 22 item sentence completion test developed by NIMH. It has standardized administration and scoring. Each item is scored 0-2, 2 indicating higher levels of comprehension. A score of < 20 means further evaluation is needed with the CAI (see below).

Example: "When I go to court, my lawyer will …"

Comments on the CST: The strengths of this test are its ease of administration and high true-negative rate. Its weaknesses include low validity, unproven reliability and high rate of false positives.

2. Competency to Stand Trial Assessment Instrument (CAI)

This is a semi-structured interview scored on a 5-point Likert scale (from total incapacity to no incapacity). The CAI evaluates 13 different functions: 1. Appraisal of available legal defenses; 2. Level of unmanageable behavior; 3. Quality of relating to attorney; 4. Ability to plan legal strategy; 5. Ability to appraise the roles of participants in courtroom proceedings; 6. Understanding of court procedure; 7. Appreciation of the charges; 8. Appreciation of the range and nature of possible penalties; 9. Appreciation of likely outcome; 10. Capacity to disclose to the attorney available pertinent facts surrounding the offense; 11. Capacity to realistically challenge prosecution witnesses; 12. Capacity to testify relevantly; and 13. Self-serving versus self-defeating motivation.

Comments on the CAI: Strengths of this test include structure and provision of sample questions and case examples. The weaknesses of this test include non-standardized administration and scoring, limited empirical validation, and no norms.

3. Georgia Court Competency Test (GCCT) and Georgia Court Competency Test-Mississippi Hospital (GCCT-MSH)

This test has 17 questions designed to assess a defendant's knowledge in four areas; understanding of courtroom procedure, knowledge of the charge, knowledge of possible penalties and ability to communicate rationally with an attorney. The 17 questions are divided into six categories: 1. picture of the Court – seven questions relating to a picture of an empty courtroom; 2. functions – five questions about the roles of the courtroom personnel; 3. charges –two questions pertaining to the nature of the charges; 4. helping the lawyer – one question about assisting the attorney; 5. alleged crime – one question about the circumstance of the pending charges; and 6. consequences – one question concerning the possible penalty.

The examiner adds the points from each answer, which is then multiplied by 2, resulting in a score up to 100; 100 reflecting the highest degree of competence. The tests creator recommends that defendants

with a score of 69 or below should undergo further evaluation.

A revised version added four questions to further investigate the defendant's understanding of courtroom procedure and his understanding of his ability to assist in his defense. The revised version also re-calculated the weights given to some of the original questions. The final scoring of 0-100 with a 69 cut-off, remain the same.

Comments on the GCCT/GCCT-MSH: Both tests have been lauded for demonstrating simplicity, reliability between different testers and predictive validity. Criticism includes that the test focuses too much on cosmetic and superficial issues (i.e. 1/3 of the test is on the picture of the court) and this, it is argued, has little to do with understanding or participating in the trial process. This is a good test of factual understanding, but the evaluator typically should follow-up with questions that help better assess rational understanding, ability to consult with counsel, and decision-making capacity because there is a risk that the GCCT is weak in assessing these components of competency to stand trial. That being said, it is very simple and easy to administer and score, it provides relevant information and thus has its place in competency assessment.

Note: The GCCT is the most commonly administered competency instrument in Louisiana.

4. Interdisciplinary Fitness Interview (IFI) and IFI Revised (IFI-R)

This is a semi-structured interview designed for joint administration by an attorney and a mental health professional (IFI-R does not require attorney presence, but encourages a detailed interview with attorney). The test examines psychopathology and psycholegal abilities in various areas: 1. Ability to appreciate charges; 2. Ability to disclose relevant information; 3. Courtroom demeanor; 4. Ability to understand adversarial nature of proceedings; 5. Quality of relationship between defendant and attorney; 6. Appreciation of legal options and consequences; and 7. Ability to make reasoned choices concerning legal options and consequences. These are scored from 0 (no or minimal incapacity) to 2 (substantial incapacity).

Comments on the IFI and IFI-R: Strengths of this test include interdisciplinary nature and good correlation between results and experts' and judges' ultimate conclusions. The weaknesses are practical difficulties of involving the attorney and limited research on reliability and validity.

5. The MacArthur Competence Assessment Tool-Criminal Adjudication (MacCAT-CA)

The MacCAT-CA is the abbreviated version of a longer, more cumbersome competence research tool, the MacSAC-CD. The MacCAT- CA uses a vignette format. The defendant is told about a hypothetical defendant charged with aggravated assault and asked 16 questions about the prosecution of the hypothetical defendant. The defendant is then asked questions about his own situation with a total of 22 questions. The test is designed to evaluate the defendant's factual *understanding* of the legal system, his *reasoning* skills, i.e. ability to understand the relevance of certain information and to reason about options that might arise in a legal setting; and the defendant's capacity to *appreciate* the legal situation surrounding the defendant's own case. The answers receive scores of 0-2 and the total score will fall into one of three ranges: no or minimal impairment, mild impairment and clinically significant impairment.

Comments on the MacCAT-CA: Studies have confirmed internal consistency and reliability between different testers. The test developers have identified a number of shortcomings with the test – (1) it does not factor in the complexity of the defendant's given case; (2) it does not factor in certain potentially relevant factors such as speech issues, and memory of specific case-related events.

6. The Evaluation of Competence to Stand Trial- Revised (ECST-R)

The ECST-R is a semi-structured interview composed of four competency scales. These include the following: capacity to Consult with Counsel (CWC), Factual Understanding of Courtroom Proceedings (FAC), Rational Understanding of Courtroom Proceedings (RAC), and Overall Rational Ability (Rational). The ECST-R also yields scores on five atypical presentation scales which screen for feigned incompetence: Realistic (ATP-R), Psychotic (ATP-P), No psychotic (ATP-N), Impairment (ATP-I), and both psychotic and nonpsychotic (ATP-B). In addition, the ECST-R provides a systematic screening for feigned incompetence to stand trial with questions that probe for symptomatology and impairment specifically germane to competency issues.

Comments on the ECST-R: The ECST-R was recently developed and designed with focus on the *Dusky* standard. One advantage of this test over other competency measures is that it does screen for feigned incompetence – malingering.

7. The Competence Assessment for Standing Trial for Defendants with Mental Retardation (CAST-MR)

This test has 50 items and is an orally administered, quantitative measure designed to assist in the assessment of adult defendants with mental retardation. It consists of multiple choice and unstructured response items presented in an interview. It is designed to assess three important areas of trial competence: basic legal concepts, skills to assist defense counsel, and understanding of case events. The test provides scores in these three areas, each of which can be compared to scores of study participants with mental retardation that were, or were not, ultimately found competent to stand trial. The test was specifically designed for use with defendants who have mental retardation, and thus the test is designed to be simple to administer and simple for mentally retarded defendants to understand. The National Benchbook notes that the CAST-MR is the only standardized test for assessing competence of the mentally retarded. A weakness is that it does not assess the defendant's understanding of legal proceedings in depth.

Comments on the CAST-MR: The CAST-MR is designed for use with defendants with mental retardation – distinguishing those who are not competent to stand trial from those who are.

8. Computer-Assisted Determination of Competency to Stand Trial (CADCOMP)

This is a 272-item objective test that assesses social history, psychological functioning, and legal knowledge. It produces a computer-generated narrative report. Weaknesses include administrative time, reliance on the defendant's self-report, and unfeasibility of administration in certain settings (jail).

Q: Why should mentally retarded defendants be evaluated differently than those who are mentally ill?

A: There are many differences between mentally retarded and mentally ill defendants that make it necessary to assess the two groups differently. *United States v. Duhon*, 104 F.Supp.2d 663, 671 (W.D. La. 2000) summarizes these differences: "While incompetency due to mental illness may be very different over time and may be reversible with treatment, incompetency due to mental retardation is more static and relates more directly to susceptibility than to suggestion." *Id.* Courts and attorneys should ensure competency assessments are tailored to mentally retarded defendants, which can be done by using the CAST-MR or through more general competency assessment techniques (such as interviews or competency scales) so long as the psychologist/psychiatrist focuses on the *cognitive* elements of capacity. See *id* at 671.

It is important to remember that mental retardation creates functional behavior limitations that can make restoration simply impossible. The ability of the mentally retarded defendant to rote memorize trial elements does not mean he can intelligently make legal decisions or participate in his defense. See *id* at 675.

Practice Point:

If you are not satisfied with the outcome of your client's evaluation, either by the Sanity Commission or an independent expert, it may be useful to challenge the failure to utilize a testing instrument, or the choice of testing instrument, or the way in which the testing instrument was administered.

Practice Point:

Evaluators typically do not base a decision on competence to stand trial solely on the results of psychological testing, and it is not uncommon for test results to contrast with final opinions regarding competence to stand trial. When scores on tests do not correlate with the opinion regarding competence to stand trial, it is a good idea to ask why, if it is not explained in the report.

Q: What does a diagnosis of malingering mean?

A: DSM-IV TR allows for a diagnosis of malingering, which can have very negative connotations and should not be offered lightly. In at least two federal cases, appeals courts have held that *deliberate efforts to feign mental problems could be ground for imposing longer prison terms under federal sentencing guidelines*. *United States v. Greer*, 158 F.3d 228, 237-38 (5th Cir. 1998), and *United States. v. Binion*, 132 Fed. Appx. 89, 92-93 (8th Cir. 2005). Obstruction of justice can justify a sentence enhancement.

Examiners should base diagnoses of malingering on solid evidence rather than mere suspicion. There are specialized instruments for detecting malingering (M-FAST, SIRS, GCCT-MSH, AP Scale, REY 15 item). Examiners should interview friends, family, police, custodial officers and others who have had contact with the defendant. Examiners should look for previous history with criminal justice system without any evidence or suspicion of incompetence. Reports from the 1990s suggest that at least 10% of defendants referred for competence evaluations attempt to feign mental problems.

MALINGERING

The act of intentionally feigning or exaggerating psychological symptoms or disability to avoid legal consequences.

According to the DSM-IV TR, when any of the following are observed, malingering is suspected:

1. Medicolegal context of presentation
2. Marked discrepancy between the person's claimed stress of disability and the objective findings
3. Lack of cooperation during the diagnostic evaluation and in complying with prescribed treatment regimen
4. The presence of Antisocial Personality Disorder

Some tests commonly used to determine malingering are:

1. Structured Interview of Reported Symptoms (SIRS): designed specifically to detect malingering
2. The Test of Memory Malingering (TOMM)
3. Recognition Memory Test
4. Minnesota Multiphasic Personality Inventory (MMPI)

Practice Point:

If an expert mentions malingering concerns about your client, question the expert on the tests administered and basis for the determination. Remember: a malingering diagnosis can be extremely harmful to your client.

The Sanity Commission Report:

Within 30 days of its appointment, the Sanity Commission is required to file its report with the judge. Both the State and the defense are entitled to a copy. La. Code Crim. P. art. 645(B). The report must discuss your client's capacity to understand the proceedings, his ability to assist in his defense, and his need for inpatient hospitalization in the event he is found incompetent. La. Code Crim. P. art. 645(A)(1).

Practice Point:

In some Louisiana jurisdictions it is the practice for the Sanity Commission to evaluate your client immediately prior to testifying at the Competency Hearing. In these instances you would not have the Sanity Commission report available in time to prepare adequately for the hearing. Article 647, La. Code Crim. P. provides that the Sanity Commission report is admissible at the competency hearing; this implies and presupposes that the parties have the Sanity Commission report prior to the hearing. Accordingly, you should consider requesting a continuance of the hearing until the Sanity Commission has provided the court, defense and State with a copy of the report as it is required to do under La. Code Crim. P. art. 645(B).

Preparing for the Hearing

Independent defense experts are permitted – The defense is entitled to conduct an independent examination by a mental health professional, in addition to that conducted by the Sanity Commission. La. Code Crim. P. art 646. You should consider the value of obtaining an independent mental health expert to conduct and testify as to his/her independent evaluation, as well as to challenge the validity or reliability of the testing/evaluating method utilized by the Sanity Commission or the State's independent expert. See the discussion above explaining some of the various forensic psychiatry instruments that may be utilized.

Gathering records and witnesses – The defense may subpoena witnesses to attend the examination. La. Code Crim. P. art 644(B).

Possible Documentary Evidence	**Possible Witnesses**
All medical and psychiatric records	Family members
School records, including discipline records	School teachers
Mentors Sports	Coaches
Military records	Clergy
Records relating to any disability benefits, e.g. social security, veterans benefits	
Employment records	
Jail and prison records	

Witnesses and records may be able to establish the history of your client's mental health, the severity of his condition and other factors that the judge may consider when making the competency determination.

Providing the expert with background information – As with the Sanity Commission, you will want to provide your expert with as much useful information about the background of your client as possible. This may include records, such as those listed above, or information provided by witnesses, such as those listed above. You should consider having helpful witnesses either meet with the expert or provide the expert with a statement and/or letter. Of course, it is essential that you carefully review these records and or statements prior to providing them to the expert to ensure that there is nothing in them that might be harmful to your client.

The Competency (a.k.a. Lunacy) Hearing:

The Burden of Proof
There is a presumption of competence. Placing the burden on the defendant is not a violation of due process. *Medina v. California*, 505 U.S. 437 (1992).

Incompetence must be proved by a ***preponderance of the evidence***. *Cooper v. Oklahoma*, 517 U.S. 348, 355 (1996); La. Code Crim. P. art. 648(A) (as amended by Acts 2008, No. 861, eff. July 9, 2008).

Prior to July 9, 2008 *La. Code Crim. art. 648 was unconstitutional.* Before July 9, 2008, Article 648A provided that incompetence must be proven by clear and convincing evidence in violation of *Cooper v. Oklahoma*, 517 U.S. 348 (1996). On July 9, 2008, Act No. 861 took effect, amending LA Code Crim. P. art. 648(A) to conform to *Cooper*.

The *Bennett* Criteria - *The Bennett criteria are the factors that the court should consider, with the insight offered by the other evidence presented, including the Sanity Commission, to determine if your client is competent.*

On rehearing in *State v. Bennett*, 345 So. 2d 1129 (La. 1977), the Louisiana Supreme Court set out appropriate considerations to determine whether the defendant satisfies the two *Dusky* prongs.

Nature of the proceedings – (1st *Dusky* prong)
Does the defendant understand:

1. the nature of the charge(s) and appreciate their seriousness?
2. the defenses available and distinguish a guilty plea from not guilty and the consequence of each?
3. his legal rights?
4. the range of possible verdicts and consequence of conviction?

(*State v. Bennett*, 345 So. 2d at 1138.)

Ability to assist in defense – (2nd *Dusky* prong)
Is the defendant:

1. able to recall and relate facts?
2. assist in locating and examining witnesses?
3. able to maintain a consistent defense?
4. able to listen to testimony and communicate misstatements?
5. able to make simple decisions in response to well-explained alternatives?
6. capable of testifying in his own defense?
7. to what extent will his condition deteriorate under stress of trial?

(*State v. Bennett*, 345 So. 2d at 1138.)

***Note*: Competence is a legal finding to be made by the judge, not the expert.** In *Bennett*, the Louisiana Supreme Court explained that, "the trial court may not rely so extensively upon medical testimony as to commit the ultimate decision of competency to the physician." *Bennett*, 345 So.2d at 1137.

***Note*:** The roll of the expert/psychiatrist is to provide descriptive information relating to competence, not conclusion.

Again in *Bennett*, the Louisiana Supreme Court stated, "To the extent that psychiatric testimony is utilized, however, it should be descriptive of the defendant's condition rather than conclusory. Like criminal responsibility, incompetence is a legal question; the ultimate responsibility for its determination must rest in a judicial rather than a medical authority." *Bennett*, 345 So.2d at 1137.

The Sanity Commission report is *prima facie* evidence of the correctness of the findings of the Commission

La.R.S. 15:425 states that, "The report of every commission of lunacy shall be *prima facie* evidence of the facts recited in such report and of the correctness of the findings of such commission." The Sanity Commission report is not conclusive but it is given much weight, and courts may not arbitrarily reach a decision contrary to it. *State v. Whisenant*, 247 La. 987, 998, 175 So. 2d 293, 296 (1965). Where the Sanity Commission finds the defendant insane, the presumption of sanity disappears and the Commission's conclusion can be overcome only by proof. *State v. Patterson*, 176 La. 440, 446, 146 So. 17, 19 (1933). Evidence to rebut the conclusion of the Sanity Commission is permissible, and the ultimate decision should take into account all evidence presented.

Expert testimony must conform to standards laid out in *Daubert*

United States v. Duhon, 104 F. Supp. 2d 663, 677 (W.D. La.), held that expert testimony as to competence must conform with the *Daubert* test used to ensure reliability of expert testimony. *Daubert v. Merrell Dow Pharmaceuticals, Inc.*, 509 U.S. 579 (1993). The test is 1) whether a theory or technique can be or has been tested; 2) whether it has been subjected to peer review and publication; 3) the theory's known or potential rate of error and the existence and maintenance of standards and controls; 4) the theory's general acceptance in the relevant community. Be sure the Sanity Commission's testimony, and that of all other experts present at the hearing, conforms to the above standards and that he/she is able to substantiate such compliance. You can also use the *Daubert* test to challenge an expert's testing methods or opinions.

Practice Point:

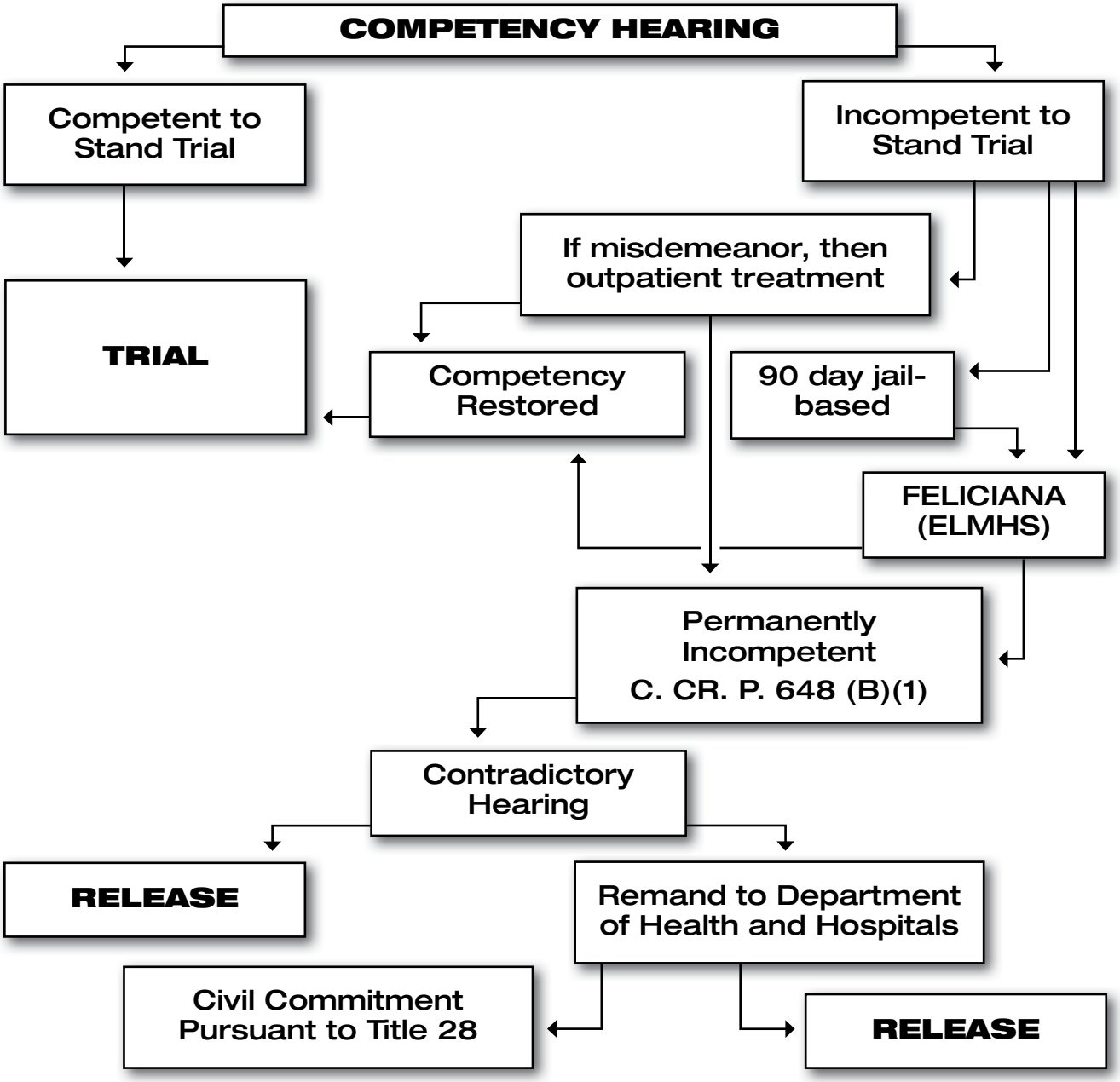
If you anticipate that your client will be found *competent* to stand trial you may want to establish, through the experts, that the stresses of trial, your client's continued incarceration and any other relevant factors may have a negative effect on your client's mental health and future competence. This will facilitate your ability to re-visit the issue of competence later on, if your client takes a turn for the worse.

Practice Point:

If you anticipate that your client will be found *incompetent* to stand trial and this incompetence is solely or largely based on mental retardation or organic brain damage, make sure this is clear on the record; then elicit testimony that mental retardation and organic brain damage are not treatable or curable and thus your client's restoration prognosis is poor. (See *United States v. Duhon,* 104 F. Supp. 2d 663, 679-81 (W.D. La. 2000) for an excellent discussion of this issue.) Of course, the expert may not concede this fact if your client is borderline mentally retarded. The advantage to doing this is that you may be able to persuade the judge that your client is permanently incompetent without subjecting your client to extended and futile restoration treatment.

Part C. Post-Competency

Post-Competency Hearing Procedures:



Note: Your client's time in custody, care and treatment may not exceed the maximum possible sentence for the crime with which your client is charged. La. Code Crim. P. art. 648(B)(1)

If Your Client is Found Competent

If your client is found competent, then criminal proceedings resume. See La. Code Crim. P. art. 648(A). However, if, as you proceed through the criminal process, there are *reasonable grounds* to believe that your client's condition has changed and that he is now incompetent, the issue must be revisited. La.

Code Crim. P. art 642 ("The defendant's mental incapacity to proceed may be raised at any time …."); *Id.* art. 643 (examination required when the court "has reasonable ground to doubt the defendant's mental capacity to proceed.").

The standard of review on appeal, of the trial court's finding of competence, is the abuse of discretion standard. The determination of the trial judge is entitled to great weight on appeal. *State v. Perry,* 502 So. 2d 543, 549 (La. 1986)**;** *State v. Brooks,* 541 So.2d 801, 807 (La. 1989); *State v. Jones,* 376 So.2d 125, 127 (La. 1979); *State v. Morris,* 340 So.2d 195, 203 (La. 1976). Thus, trial judge's determination will not be overturned on appeal absent manifest error. *State v. Perry*, 502 So.2d at 549.

If Your Client is Found Incompetent

90 Day Jail-Based Treatment *or* Remand to Feliciana (ELMHS)

Note: Article 648, La. Code Crim. P., refers to "Feliciana Forensic Facility", however, the name has been changed to Eastern Louisiana Mental Health System (ELMHS)–Forensic Division**.**

- **Non-violent misdemeanor - outpatient treatment (while in custody or out on bond)**
  If your client is charged with non-violent misdemeanor then the court may order outpatient treatment while your client remains in custody or while he is out on bond. La. Code Crim. P. art 648(A)(1).

- **Felony and competency likely to be restored within 90 days (jail-based treatment)**
  If your client is charged with a felony or misdemeanor (classified as an offense against the person) and competency is likely to be restored within 90 days, then the court may order immediate jail-based treatment by the Department of Health and Hospitals. La. Code Crim. P. art. 648(A)(2)(a).

After 90 days of jail-based treatment – If, after an evaluation and hearing, the court determines that competence has been restored, then criminal proceedings will resume. If competence has not been restored, then the court must remand your client to Feliciana (ELMHS).

- **Misdemeanor and competency *not* likely to be restored within 90 days –** If your client is found incompetent for a misdemeanor charge classified as an offense against a person (except for those listed in La. R.S. 14:35.3 pertaining to domestic abuse) and competency is NOT likely to be restored within 90 days, the court shall order your client to outpatient treatment or other appropriate treatment. La. Code of Crim. P. art 648A(2)(c). *Note: If you are in a rural parish, the availability of outpatient services may be a problem.*

- **Felony and competency *not* likely to be restored within 90 days – remand to Feliciana –** If your client is charged with a felony or misdemeanor (classified as an offense against the person) and competency is NOT likely to be restored within 90 days**,** then the court shall commit your client to Feliciana (ELMHS). La. Code Crim. P. art. 648(A)(2)(a).

- **If practicing in Orleans Parish,** *See State v. Morgan, et al.,* 48 So.3d 274 (La. 2010), which affirmed the Louisiana Fourth Circuit Court of Appeal's order to remand defedants to the Department of Health Hospitals pursuant to the new La. Code of Crim. P. art 648(B)(3). The Court also noted that until the repeal of La. R.S. 13:1336 and 13:1338, DHH shall institute civil proceedings pursuant to Title 28 in the Criminal District Court of Orleans Parish who has limited civil jurisdiction pursuant to La. R.S. 13:1336(C)(2). *Id.*

Practice Point:
Immediate remand to Feliciana may be more desirable than 90 day jail-based treatment.

Once a defendant is remanded to Feliciana (ELMHS), he is placed on a waiting list until a bed is available for him and he can be transported to Feliciana (ELMHS). This means that your client may wait months and some cases more than a year, before actually being transferred from jail to the hospital. In light of this delay, it is recommended that you consider seeking an immediate remand to Feliciana (ELMHS) with an order that while your client remains in jail waiting for the remand order to be executed he receive appropriate jail- based treatment. Otherwise, your client will not be placed on the waiting list until after the ninety day jail-based treatment has failed.

***Note*:** Do not assume that because the court ordered your client remanded to Feliciana that he actually will go to Feliciana. Feliciana (ELMHS) does not have adequate beds for the number of defendants who are ordered to its facility. The bed shortage is even more severe for women. Consequently, your client may wait in jail for months and in some cases for more than a year, before being transported to Feliciana (ELMHS). Recently, a federal injunction has mandated that pre-trial detainees ordered to Feliciana must be transported there within 21 days of the court order. If your client is ordered to Feliciana check on the 22nd day to see if your client is still in local custody. If so, defense counsel should file a motion compelling transfer and pointing out that Feliciana is in contempt of a federal court order. See, Court Order, *Advocacy Center, et al. v. Louisiana Dept. of Health and Hospitals*, 2:10-cv-01088 (E.D. La. August 9, 2010). At the time of this publication, the parties in the above suit were attempting to reach a consent decree which would formalize how long the Department of Health and Hospitals has to transfer your client from local custody to Feliciana.

***Note*:** The federal district court, in *Advocacy Center, et al. v. Louisiana Dept. of Health and Hospitals*, found that, "[t]he level of mental health treatment in parish jails falls far short of the care available at Feliciana. …the treatment available in these jails is far below the articulated standard of care." *Id.* at 21. The order also reasoned that, "lack of funding cannot justify the continued detention of defendants who have not been convincted of any crime, who are not awaiting trial, and who are receiving next to no mental health services." *Id. at 49.*

Feliciana: Transfer and Treatment

Getting your client transferred to Feliciana:

As noted above, the waiting list to get into Feliciana (ELMHS) can be very long. Your client will not be admitted to Feliciana (ELMHS) unless Sheila Jordan, the current Administrative Specialist has the following:

1. name and address of the defense attorney
2. crime(s) with which defendant is charged and the date of the charge
3. copy of the Sanity Commission Report
4. other information/records related to defendant's present health condition
5. defendant's criminal history record (rap sheet)
6. police report relating to charged offense
7. copy of the order remanding the defendant to Feliciana

(These items are listed in La. Code Crim. P. art. 648.1). Consequently, you can avoid any unnecessary

delays in transfer by ensuring that Feliciana (ELMHS) has the documentation that it requires. They may be mailed to Ms. Sheila Jordan, Administrative Specialist, Community Forensic Services, P.O. Box 888, Jackson, LA 70748; telephone number (225) 634-0221.

What to do if your client sits in jail waiting for transfer to Feliciana:

- **Pursuant to La. Code Crim. P. art. 648 A(2)(d)**, after 180 days in jail the court shall hold a status hearing to determine if a contradictory hearing is warranted – the contradictory hearing would consider whether there was sufficient change in either the defendant's condition or the circumstances such that the previous court order should be modified;

- **Seek contempt ruling** pursuant to La. Code Crim. P. art 23(2). The court issued an order with which the Sheriff and/or Department of Health and Hospitals (DHH) is failing to comply. This constitutes constructive contempt which is punishable by a fine of not more than $500 or imprisonment for not more than six months or both. La. Code Crim. P. art. 25. However, the likely defense to an allegation of contempt is that the failure to comply is not willful, but the result of a bed shortage which is not within the control of DHH. Thus the only advantage to this approach may fall under "the squeaky wheel gets the oil" doctrine. If you are a persistent advocate, your client may get the next bed at Feliciana (ELMHS).

- **Writ of Habeas Corpus** is an appropriate procedural tool when your client is being held in custody in violation of his constitutional rights. La. Code Crim. P. art. 351 et seq. Continued incarceration of a defendant after he has been found incompetent to stand trial is only consistent with due process if it is for a reasonable period of time necessary to determine whether there is a substantial probability he will attain [the] capacity [to stand trial] in the foreseeable future." *Jackson v. Indiana*, 406 U.S. 715, 738 (1972); see also *State ex rel. Lockhart v. Armistead*, 351 So. 2d 496 (La. 1977) (adopting the holding of *Jackson*). The *Jackson* Court specifically noted that "…even if it is determined that the defendant probably soon will be able to stand trial, his continued commitment must be justified by progress toward that goal [the goal of restoring competence]." *Jackson v. Indiana*, 460 U.S. at 738. Thus, if your client has been continuously incarcerated in jail for a prolonged period of time and you can demonstrate that no meaningful or specific efforts have been made to restore his competence while in jail, then arguably his continued incarceration is a violation of his due process rights. *Note:* If the Louisiana courts fail to adhere to the established law, defense counsel should seek federal writ of habeas corpus under 28 U.S.C. § 2241.

Treatment at Feliciana (ELMHS):

Forced medication to restore competency may be permissible. In *Sell v. United States*, 539 U.S. 166, 179 (2003), the United States Supreme Court held that the government may involuntarily administer anti-psychotic drugs to a criminal defendant solely to render him competent to stand trial, at least in those cases meeting the criteria set out by the court. In deciding whether the involuntary medication is appropriate, the court must balance the following factors: 1. whether there is a substantial state interest in having a criminal trial, taking into account any civil confinement for the mental condition; 2. whether the medication is substantially likely to render the defendant competent without offsetting side effects; 3. whether the medications are necessary or whether a less intrusive alternative procedure would produce substantially the same result; and 4. whether the drugs are medically appropriate.

The effectiveness of "competency restoration programs" has been called into question. In *United States v. Duhon*, 104 F. Supp. 2d 663 (W. D. La. 2000), the court questioned the effectiveness of competency restoration programs commonly used in mental health facilities in an attempt to teach incompetent defendants the information necessary to pass the *Dusky/Drope* test. One expert in the *Duhon* case stated,

"[a]t best intervention programs may effect rote repetition of conditioned verbalizations regarding the above requirements to reach competence, but these conditioned verbalizations will be hollow and without cognitive understanding or appreciation of content." *Id.* at 675. Defendants may be able to memorize basics of the legal system through the programs, but the programs fall far short of teaching defendants to consult with their attorneys with a reasonable degree of rational understanding or assist in their defense.

As mentioned above, expert testimony as to competence must conform with the *Daubert* test. *Daubert v. Merrell Dow Pharmaceuticals, Inc.*, 509 U.S. 579 (1993). Under this standard, it seems expert testimony of restored competence due to competency restoration programs should be deemed unreliable. The technique has not been tested, peer reviewed or published; nothing is known as to its potential for error or standards; and the psychological community generally deems it ineffective. If your client has been deemed competent after completing the competency restoration program but you still have serious doubts as to his/her competence, it may be fruitful to challenge the program's validity.

Restoration Review: Restoration review 60 days, 120 days and then every 180 thereafter

The medical staff at Feliciana (ELMHS) is required to evaluate your client's condition after the first 60 days, then after 120 days and then every 180 days **thereafter, to determine if he is presently capable of standing trial. La. R.S. 15:211. The treating physician should provide you, the court and the district attorney with a report** reflecting the findings of these evaluations.

If Competence is Restored

If, after commitment to Feliciana (ELMHS), the superintendent reports to the committing court that your client is now competent to proceed to trial, then your client will be transferred to the custody of the sheriff, and the court shall hold a contradictory hearing within thirty (30) days to determine if, as a matter of law, your client is now competent to stand trial. La. Code Crim. P. art. 649(A). After a hearing, if the court determines that your client has regained capacity, then criminal proceedings will resume. La. Code Crim. P. art. 649(E).

Medications after returning to jail - The Sheriff is required to provide your client with the medications ordered by the doctors at Feliciana (ELMHS), until the coroner or other doctor finds that the medications or the previously prescribed dosage are no longer necessary La. Code Crim. P. art. 649.1.

Practice Point:

Frequently the Sheriff will fail to provide your client with the same medications he was receiving at Feliciana (ELMHS). This may be true because often such medications are very expensive and/or because he does not have medical personnel to monitor their administration. As a consequence your client may relapse and again become incompetent to stand trial. This scenario can result in a repeated cycle and may require specific court orders to the Sheriff or other monitoring in order to break this cycle.

Q: Does my client have a right receive credit for time served while his competency was being restored?

A: No. The Ninth Circuit Court of Appeals held that a defendant is not denied equal protection by not receiving credit towards his sentence for time spent in a state mental hospital prior to trial to determine competency to stand trial. *Makal v. Arizona*, 544 F.2d 1030 (9th Cir. 1976). The defendant was given credit for all presentence time in state penal institutions, but not for time spent in the state hospital due to his mental illness. *Id*. at 1035. The Court of Appeals of Utah upheld a trial court's refusal to give defendant credit for time spent in a state hospital to determine competency. *State v. Fife*, 911 P.2d 989 (Utah App. 1996). The court held that the equal protection, due process and double jeopardy clauses do not require that a defendant receive credit for time spent in a state hospital pending competency determination. *Id.* at 991-995.

If Competence Not Restorable in Foreseeable Future (Permanent Incompetence)

After commitment to Feliciana (ELMHS), if the superintendent advises that your client will not have competency restored within the foreseeable future then the court shall hold a hearing within sixty days to determine if, as a matter of law, your client is permanently incompetent.

If after a hearing, your client is found to be **permanently incompetent** then the court must **release or remand to Department of Health and Hospitals.** La. Code Crim. P. art. 648(B)(3), as enacted by Acts 2008, No. 861.

Practice Point:

It seems likely that the primary issue at this hearing will be dangerousness. Under the old law, before the amendment of La. Code Crim. P. art. 648(B)(3) in 2008, a contradictory hearing was held focusing on the issue of dangerousness. The determination of dangerousness led to either release or art. 648(B)(3) commitment. Since we are still dealing with whether to release or commit, it can be presumed that the hearing under La. Code Crim. P. art. 648(B)(3) will have the same focus.

Definition of Dangerousness: "Dangerous to others" means the condition of a person whose behavior or significant threats support a reasonable expectation that there is a substantial risk that he will inflict physical harm upon another person in the near future. La. R.S. 28:2(3).

Evidence other than charge is required to prove dangerousness. Dangerousness may not be solely proven by the fact of the charged offense. To do so presupposes guilt of the charged offense, in violation of due process. *See Jackson v. Indiana*, 406 U.S. 715, 724 (1972).

Note: **The American Psychiatric Association (APA) maintains that future dangerousness cannot be predicted, even by psychiatrists.** In *Barefoot v. Estelle,* 463 U.S. 880 (1983), a death penalty appeal, the APA submitted an amicus brief in which it explained that no one, including psychiatrists, can predict with any degree of reliability that an individual will commit other crimes in the future. Nonetheless, the U.S. Supreme Court in *Barefoot* held that psychiatric testimony as to dangerousness may be admissible, despite its unreliability, because to disallow such testimony would be like "disinvent[ing] the wheel." *Barefoot, 463 U.S.* at 896.

DHH has 10 days to civilly commit or release. The Department of Health and Hospitals, which runs Feliciana, then has ten working days to either institute the standard civil commitment procedures contained in Title 28 of the Louisiana Revised Statutes of 1950, or release the defendant. La. Code Crim. P. art. 648(B)(3).

The defendant remains in custody pending civil commitment proceeding: La. Code Crim. P. art. 648(B)(3) mandates that a permanently incompetent defendant must remain in custody pending the civil commitment proceedings.

Dismissal of Charges

If your client has been found permanently incompetent to stand trial then the charges against him can be dismissed without prejudice. With specific identified exceptions, the charges against your client must be dismissed five years after his arrest or the date the maximum sentence would have expired had he been convicted, whichever is sooner. La. Code Crim. P. art 648(B)(3). The exceptions are listed in La. Code Crim. P. art. 648(B)(3)(a)-(x). They include crimes of violence as defined in R.S. 14:2(B), charges against a client who has been convicted of a felony within 10 years prior to the date charged on the current offense, and an additional 21 other named charges.

***Note*:** Incompetent defendants charged with a sex offense not have to register as sex offenders.

In Louisiana, as well as other states, incompetent defendants charged with a sex offense are incurring an extra complication—they are being told they must register as sex offenders or face the harsh penalties that come with failure to comply.

Louisiana sex registration law reads: "Any adult residing in this state who has pled guilty to, has been convicted of or where adjudication has been deferred or withheld for the perpetration or attempted perpetration of any sex offense…shall register with the sheriff of the parish of the person's residence." La. R.S. 15:542(A).

Louisiana Atty. Gen. Opinion says incompetent defendants do not have to register as sex offenders because they do not meet the criteria outlined above. La. Atty. Gen. Op. 03-0435, 2004 La. AG LEXIS 3 (Jan. 30, 2004). The Attorney General clarified that "adjudication deferred or withheld" pertains to criminal cases where the defendant has resolved his case by "either making some form of admission of guilt or by agreeing with the Court to take responsibility for the crime charged in return for some type of probationary type sentence." *Id.* Delay of proceedings due to incompetence does not fall under these terms. Incompetent defendants, who have not stood trial or pled guilty to a charged sex offense, are not required to register as sex offenders as they have no adverse adjudication, such as a conviction or a finding of not guilty by reason of insanity. *Id.*

Part D. The Habeas Template

STATE OF LOUISIANA	**CRIMINAL DISTRICT COURT**
versus	**PARISH OF**
DEFENDANT	**CASE NO.**

PETITION FOR WRIT OF HABEAS CORPUS

NOW INTO COURT, through undersigned counsel, comes the defendant, (insert name of defendant), who respectfully submits this Petition for a Writ of Habeas Corpus, pursuant to the Louisiana Constitution, Article I, Section 21, and La. Code Crim. P. art. 351, et seq.

Petitioner is being held in the custody of (insert name of custodian), at (insert location of defendant), accused of violating La.R.S. 14:(insert statute number), as set forth in the Bill of Information or Indictment. Petitioner is being held in the custody of (insert name of custodian) without the authority of law. Such an unlawful detention violates Petitioner's rights under the Louisiana Constitution of 1974 and the United States Constitution as a denial of the right to due process of law and equal protection under the laws.

STATEMENT OF FACTS

Petitioner was arrested on (insert date) for an alleged violation of La.R.S. 14: (insert statute number). On (insert date), Petitioner's competence to stand trial was raised by (person who raised competence). Accordingly, this Court ordered the Petitioner be examined by the Sanity Commission and set a contradictory hearing on the issue of competence for (insert date). Upon examination by the Sanity Commission, Petitioner was found incompetent to proceed on (insert date). On that date, pursuant to La. Code Crim. P. art. 648, this Court suspended criminal proceedings against the Petitioner and remanded Petitioner to the custody of the Feliciana Forensic Facility section of the Eastern Louisiana Mental Health System.

As of today, Petitioner continues to be held in the custody of (insert place of custody) and has never been remanded to the Feliciana Forensic Facility for treatment. Further, Petitioner has not received the immediate jail-based treatment by the Department of Health and Hospitals required by La. Code Crim. P. art. 648(A)(2).

Petitioner has now served (number of days since arrest) days in jail, (number of days since date of incompetence) days since this Court found him incompetent to proceed, in violation of La. Code Crim. P. art. 648(A)(2)'s mandate that efforts to restore the defendant's competence not exceed 90 days.

STATEMENT OF JURISDICTION

This Court has jurisdiction to hear this Petition for a Writ of Habeas Corpus pursuant to the Louisiana Constitution of 1974, art. 21, which states that the writ of habeas corpus shall not be suspended, and La. Code Crim. P. art. 352, which states that habeas corpus proceedings shall be instituted in the parish in which the person is in custody. Petitioner is in the custody of (name of custodian), (title of custodian); as such, this Court is of competent jurisdiction to hear Petitioner's Writ of Habeas Corpus.

ARGUMENT

(Insert name of defendant) petitions this Court for a Writ of Habeas Corpus pursuant to La. Code Crim. P. art. 362(2) because his original custody, while lawful, has become unlawful, and La. Code Crim. P. art. 362(7) because he is being held prior to trial in violation of due process of law. Petitioner's custody has become unlawful because upon this Court's determination that he is incompetent to stand trial, the criminal proceedings against him have been suspended; and his continued custody is not reasonably related to the goal of restoration of competence. As a result, Petitioner is being held in violation of his right to due process of law as established by the United States Supreme Court in *Jackson v. Indiana*, 406 U.S. 715 (1972) and adopted by the Louisiana Supreme Court in *State ex rel. Lockhart v. Armistead*, 351 So.2d 496 (La. 1977). This continued incarceration amounts to punishment and violates Petitioner's right to equal protection of the laws.

I. PETITIONER WAS FOUND INCOMPETENT TO STAND TRIAL, THEREFORE CRIMINAL PROCEEDINGS AGAINST HIM HAVE BEEN SUSPENDED

To stand trial, a criminal defendant must possess the ability to communicate with his lawyer with a reasonable degree of understanding, and possess a factual and rational understanding of the proceedings against him. *Dusky v. United States*, 362 U.S. 402, 402 (1960). These abilities are necessary for the defendant to effectively participate in his case and therefore are required to ensure due process. *State v. Bennett*, 345 So.2d 1129, 1137 (La. 1977) (reh'g). After eliciting an examination of Petitioner by the Sanity Commission, this Court determined at a contradictory hearing on (insert date) that Petitioner was incompetent to stand to trial. This finding suspended all criminal proceedings against (insert name of defendant). La. Code. Crim. P. art. 642; *Drope v. Mo.*, 420 U.S. 162, 171 (1975) ("It has long been accepted that a person whose mental

condition is such that he lacks the capacity to understand the nature and object of the proceedings against him, to consult with counsel, and to assist in preparing his defense may not be subjected to trial.").

The State cannot continue to confine (insert name of defendant) on account of a pending criminal prosecution, since the criminal prosecution has been suspended. Therefore, the only permissible reason for continued detention of the Petitioner is to allow the State to try to restore competence so that Petitioner may stand trial. Continued incarceration must be reasonably related to the goal of restoration and may not carry on indefinitely; the State has a limited time to restore competence.

II. THE STATE HAS EXCEEDED THE AMOUNT OF TIME ALLOWED TO RESTORE PETITIONER TO COMPETENCY

The State has a right to administer treatment to a criminal defendant in order to render him competent to stand trial. *Sell v. U. S.*, 539 U.S. 166, 180 (2003). However, this right is not boundless: the State cannot indefinitely detain a criminal defendant solely on account of his incompetence. Rather, a State must not detain an incompetent defendant for more than a reasonable time to determine whether competence can be restored in the foreseeable future. *Jackson v. Ind.*, 406 U.S. 715, 738 (1972); *State ex rel. Lockhart v. Armistead*, 351 So.2d 496, 498 (La. 1977).

On (insert date), (insert name of defendant) was found incompetent to stand trial and the criminal proceedings against him were suspended. Since that day, Petitioner has remained in the custody of (insert name of custodian) at the (insert location of defendant). Not only has this detention has far exceeded the ninety-day limit to determine restorability prescribed by La. Code Crim. P. art. 648, it violates the constitutional standard set forth in *Jackson*. As discussed, the criminal proceedings against the Petitioner have been suspended, and the State has detained the Petitioner in excess of the time to determine restorability. Therefore, Petitioner must be released because his incarceration is unlawful.

III. PETITIONER IS BEING HELD IN VIOLATION OF HIS RIGHT TO DUE PROCESS OF LAW

No criminal defendant shall be deprived of liberty without due process of law. U.S. Const. amend. XIV; La. Const. art. I, § 2. In the instant case, (insert name of defendant) has been, and continues indefinitely to be, deprived of his liberty, solely on account of his incompetence to proceed to trial. His custody on this account is violative of his right to due process. *Jackson v. Ind.*, 406 U.S. 715, 738 (1972); *State v. Denson*, 04-0846 pp. 6–7 (La. 12/01/04), 888 So. 2d 805, 809 (La. 2004). Petitioner's right to due process of law is further violated because he has not been transferred to the custody of the Feliciana Forensic Facility and the State has not taken actions commensurate with an effort to restore him to adjudicative competence. At

a minimum, due process requires the nature and period of commitment of an incompetent defendant to be reasonably related to the goal of restoration to competency. *Jackson v. Ind.*, 406 U.S. at 738. The nature of (insert name of defendant)'s custody is not related to restoration of competency, but is akin to imprisonment upon conviction of a crime. The duration of (insert name of defendant)'s custody has excessively exceeded the constitutional standard of a reasonable time and the ninety-day period set forth by La. Code Crim. P. art. 648. For these reasons, Petitioner has been deprived of liberty without due process of law.

IV. PETITIONER'S CONTINUTED INCARCERATION AMOUNTS TO PUNISHMENT, IN VIOLATION OF HIS RIGHT TO EQUAL PROTECTION OF THE LAWS

Petitioner has established that the State possesses no lawful basis for his imprisonment: criminal proceedings have been suspended and continued confinement is not reasonably related to restoration of competence. *Bell v. Wolfish*, 441 U.S. 520, 539 (1979) ("[I]f a restriction or condition is not reasonably related to a legitimate goal—if it is arbitrary or purposeless—a court permissibly may infer that the purpose of the governmental action is punishment that may not be constitutionally inflicted upon [pretrial] detainees."). (insert name of defendant)'s indefinite commitment amounts to a life sentence absent a conviction, allowing the State to maintain custody of him solely on account of his adjudicative incompetence. In doing so, the State has created a class of defendants based on an impermissible characteristic, upon which it inflicts penal incarceration without first obtaining a conviction. This action amounts to a violation of Petitioner's right to equal protection of the laws.

CONCLUSION AND PRAYER FOR RELIEF

WHEREFORE, (insert name of defendant) prays that this Court, pursuant to its authority under La. Const. art. 1. 21 and La. Code Crim. P. art. 354:

1) Hold a contradictory hearing within 72 hours, directing the District Attorney of the Parish of (name of parish), State of Louisiana, to appear and show cause why Petitioner should not be discharged from the Criminal Justice System of the State of Louisiana; and directing (name of custodian) to produce, in this Court, the body and person of (name of defendant) for such hearing; and
2) After such a hearing, grant the Writ of Habeas Corpus and order Petitioner discharged from the custody of the Louisiana Criminal Justice System, or in the alternative, place Petitioner in the legal and physical custody of the Eastern Louisiana Mental Health System.

Respectfully submitted,

STATE OF LOUISIANA **CRIMINAL DISTRICT COURT**

versus **PARISH OF**

DEFENDANT **CASE NO.**

AFFIDAVIT

The allegations of fact contained herein are true to the best of my information and belief.

_____, Louisiana, this _____ day of _____, 20_____.

_____

ATTORNEY FOR PETITIONER

STATE OF LOUISIANA **CRIMINAL DISTRICT COURT**

versus **PARISH OF**

DEFENDANT **CASE NO.**

CERTIFICATE OF SERVICE

I hereby certify that a copy of the foregoing Petition for a Writ of Habeas Corpus has been served by hand on the Assistant District Attorney in Section ____ of the _____ Parish Criminal District Court on the _____ day of _____, 20_____.

_____

ATTORNEY FOR PETITIONER

STATE OF LOUISIANA **CRIMINAL DISTRICT COURT**

versus **PARISH OF**

DEFENDANT **CASE NO.**

ORDER

In consideration of the foregoing Petition for a Writ of Habeas Corpus, IT IS ORDERED that (Insert Name of Custodian) produce the body and person of (Insert Name of Defendant), in this Court, on the _____ day of _____, 20_____ at ___:___ and to then and there exhibit the lawfulness of the custody of (Insert Name of Defendant).

IT IS FURTHER ORDERED that the District Attorney, or his duly designated Assistant appear, in this Court, on the aforesaid date and time and show cause why petitioner should not be discharged from the Criminal Justice System of the State of Louisiana.

_____, Louisiana, this _____ day of _____, 20_____.

_____
JUDGE
CRIMINAL DISTRICT COURT
PARISH OF
STATE OF LOUISIANA

STATE OF LOUISIANA **CRIMINAL DISTRICT COURT**

versus **PARISH OF**

DEFENDANT **CASE NO.**

ORDER

The above-captioned matter appeared on the docket of this Court on (Insert Dates of Hearings), as scheduled, upon a Petition for a Writ of Habeas Corpus, under the authority of *Jackson v. Indiana*, 406 U.S. 715 (1972), filed on behalf of the defendant, (Insert Name of Defendant):

The Court took Judicial Notice of its own Record and Proceedings, including but not limited to the previous testimony of the Sanity Commission, previous findings and orders in connection therewith; and,

This Court, after examination of the pleadings, responses of the State, the Law and the evidence adduced herein finds as fact the following:

(Insert Name of Defendant), the defendant in the above-captioned matter and Petitioner in Writ of Habeas Corpus is incompetent to proceed to trial and is unable to assist counsel in his defense; and,

Further, the State has had more than a reasonable time within which to teach or make Petitioner competent to assist counsel and stand trial; and,

ACCORDINGLY, IT IS ORDERED THAT the Petitioner, (Insert Name), be discharged, in accordance with *Jackson v. Indiana*, from the Criminal Justice System of the State of Louisiana and detention within the Criminal Justice System be terminated within 72 hours from the date and time of this Order.

_____, Louisiana, this _____ day of _____, 20_____.

_____

JUDGE

CRIMINAL DISTRICT COURT

PARISH OF

STATE OF LOUISIANA

Section 3:
The Insanity Defense

by
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Part A. Not Guilty by Reason of Insanity: A History

History:

Despite public perception, the insanity defense is used in an estimated less than 1% of all court cases, and is only successful in 26% of these cases.[1] A successful verdict of not guilty by reason of insanity (NGRI) is rare, and it has been said the question of whether or not to present an insanity defense is "probably the most demanding task of the defense lawyer." Roberta Rosenthal Kwall, *The Use of Expert Services by Privately Retained Criminal Defense Attorneys*, 13 Loy. U. Chi. L.J. 1, 17 (1981). This section is intended to serve as a primer for defense attorneys who may present the insanity defense in a Louisiana court.

Our insanity defense has its roots in English common law, which recognizes that, "Idiots and lunatics are not chargeable for their own acts, if committed when under these incapacities." (4 W. Blackstone, Commentaries, *24, *25) A person's mental state at the time of commission of a crime often determines their level of punishment, as mental states implicate different levels of choice between good and evil -- a core concept in most systems of law. It naturally follows that if one can be punished more severely for a culpable state of mind, then one without the ability to have the requisite state of mind should not be held legally responsible.

In the UK, in 1800, Hatfield (or Hadfield) attempted to murder the King; he pled insanity. The standard was the defendant must be "lost to all sense…incapable of forming a judgment upon the consequence of the act which he is about to do." Hatfield had planned the shooting, which is contradictory to this claim, but his lawyer challenged the insanity test. The judge acquitted Hatfield, but for "his own sake" and society's, would not discharge him and he was detained at the hospital for the rest of his life. This led to the Criminal Lunatics Act of 1800. Before 1800, if the defendant was acquitted on insanity,

1 College Students overestimate 800 times the number of insanity acquittals. Legislators overestimate by 400 times. In New York there are only 2 insanity pleas for every 1000 felony arrests.

he was allowed to go free because there was no law for the government to detain him. Under the Criminal Lunatics Act, if the judge thought the defendant was guilty, they could civilly commit the defendant. The commitment was no longer at the discretion of the judge or jury, but was required when the defendant was charged with treason, murder or felony.

The first "insanity test" arose in 1843 with the case of M'Naghten, who was acquitted on grounds of insanity. M'Naghten's Case, 10 Cl. & Fin. 200, 8 Eng.Rep. 718 (1843). From his case a new formulation of the insanity defense arose which states that in order for a defendant to be found not guilty by reason of insanity, he must show he suffers from a mental disease or defect that caused him to either 1) not know the nature and quality of the act he committed, or 2) not know that the act was wrong. The first prong of the test looks at cognitive capacity, i.e. did the mental disease/defect keep the defendant from knowing what he was doing? The second prong looks at moral capacity, i.e. did the mental disease/defect keep the defendant from understanding the act was wrong?

The M'Naghten test was widely adopted by most American States, but has been criticized over the years for its failure to reflect modern psychiatric knowledge. Many tests have been created since then in an attempt to more accurately define what makes a person not guilty by reason of insanity, including the Durham Test[2], the American Law Institute (ALI) test[3], and the federal test stemming from the Insanity Defense Reform Act of 1984 (IDRA)[4], which is similar to the M'Naghten test. Louisiana, along with 24 other states, uses a version of the M'Naghten test. The insanity defense was abolished in Montana, Idaho, Utah and Kansas; a guilty but insane verdict is allowed.

Part B. The Insanity Defense in Louisiana

Questions and Answers:

What:

Q: What is the insanity defense?

A: The insanity defense is an affirmative defense.

Louisiana formulation: La. R.S. 14:14 states that an offender is exempt from criminal responsibility for his behavior when "***the circumstances indicate that because of a mental disease or mental defect the offender was incapable of distinguishing between right and wrong with reference to the conduct in question.***"

This standard is a variation of the M'Naghten test but eliminates the first prong – the cognitive capacity.

2 In 1954, the federal circuit court in D.C. adopted the *Durham* test, which says that a person is not criminally responsible if the unlawful act was a result of a mental disease. The jury had to answer "yes" to the following 2 questions to find a defendant NGRI: (1) did the defendant have a mental disease or defect? and (2) if so, was the disease or defect the reason for the unlawful act? *Durham v. US*, 214 F.2d 862 (D.C. Cir. 1954).

3 The American Law Institute states, "a person is not responsible for criminal conduct if at the time of such conduct as a result of mental disease or defect he lacks substantial capacity either to appreciate the criminality (wrongfulness) of his conduct or to conform his conduct to the requirements of the law." Model Penal Code § 4.01(1).

4 The IDRA shifted the burden of proof from the prosecution to the defense. It also eliminated the diminished capacity defense. 18 U.S.C. § 17.

Q: Is this limited formulation of the insanity defense constitutional?

A: **Yes.** There is no constitutionally minimum standard for the insanity defense and the U.S. Supreme Court has specifically upheld such limited definitions of the insanity defense as constitutional. *Clark v. Arizona*, 548 U.S. 735 (2006).

Q: Does a finding of NGRI mean the defendant committed the crime charged?

A: **Yes**. A finding of NGRI means that the defendant has committed the acts that constitute the crime, however, the defense has proven by a preponderance of the evidence that the defendant was insane at the time the acts were committed and thus cannot be held legally responsible. *Jones v. U.S.*, 463 U.S. 354 (1983).

The state has the burden to prove each element of the charged defense beyond a reasonable doubt. Only then is the issue of the defendant's insanity at the time of commission of the crime relevant. *State v. Marmillion*, 339 So.2d 788 (La. 1976). **Then the defense must prove by a preponderance of the evidence the affirmative defense of insanity.**

Q: What is a mental disease or mental defect?

A: **La. R.S. 28:2(14)** defines a mentally ill person as, "***any person with a psychiatric disorder which has substantial adverse effects on his ability to function and who requires care and treatment. It does not refer to a person suffering solely from mental retardation, epilepsy, alcoholism, or drug abuse.***"

Note: Simply having a **mental disease or defect is not sufficient** to negate criminal responsibility. The disease or defect must render the defendant incapable of knowing whether the conduct was right or wrong. *State v. Williams*, 346 So. 2d 181, 186 (La. 1977).

Note: **Courts are not bound by DSM diagnosis**. In general, the medical diagnoses of the DSM-IV-TR are used as a guide, but courts are not bound to follow them for a finding of a legal mental disease or defect. *State v. Silman*, 663 So. 2d 27, 34 (La. 1995). The *Silman* court cites an American Psychiatric Association caution against using DSM diagnosis in a forensic setting.

Exclusions:

Mental Retardation:

Louisiana specifically excludes sole mental retardation as falling under a mental disease or defect because while it may impair the ability to reason it does not necessarily impair the ability to distinguish right and wrong. "Mere weakness of mentality or subnormal intelligence does not itself constitute legal insanity." *State v. Morris*, 340 So. 2d 195, 203 (La. 1976).

Physiological and Developmental Disorders:

Some courts have considered the availability of the insanity defense to defendants with physiological and developmental disorders, such as psychometric epilepsy, hypoglycemia and minimal brain dysfunction. In *Clark v. State*, the district court was properly within its discretion to order neurological evaluation of a defendant who sought to assert the insanity defense based on commission of the crime during an epileptic seizure. 436 N.E. 2d 779 (Ind. 1982). But in *Vickers v. Arizona*, the defendant was not allowed a court appointed psychiatrist to evaluate the same defense based on epilepsy. 497 U.S. 1033 (1990). Two Supreme Court Justices dissented to the majority's denial of writ of certiorari. *Id.*at 1033-36. In *State v. Parker*, evidence of the defendant's hypoglycemia to prove an insanity defense was permitted but the defense failed. 416 So. 2d 545 (La. 1982).

A few courts have permitted evidence of genetic abnormalities to support an insanity defense, specifically the existence of an XYY gene. An NGRI verdict has been reached in at least one Australian case (where the M'Naghten test is used) based on such evidence but has not been successful in American jurisdictions. [Michael L. Perlin, *"Big Ideas, Images, and Distorted Facts: The Insanity Defense, Genetics, and the Political World." Genetics and Criminality: The Potential Misuse of Scientific Information in Court*, p. 37 (Jeffrey Botkin et al. eds. 1999) (Cited in *Texas Law Made This Mad Woman Sane*, 42 Hous. L. Rev. 1487, 1513 n. 226 (2006)).

Intoxication:

The use of drugs or alcohol at the time of commission of an offense is not proof of a mental disease or defect. *State v. Wry*, 591 So. 2d 774 (La. App. 2d Cir. 1991). In *State v. Gleason*, 836 So. 2d 1165 (La. App. 2d Cir. 2003), at trial the defendant was allowed to introduce expert testimony that the Prozac he consumed caused him to not be able to distinguish right from wrong. *Id.* at 1171. However, the jury did not reach a verdict of NGRI and on appeal the court upheld the decision. *Id.* at 1172.

Syndromes:

Posttraumatic Stress Syndrome is a recognized mental disorder, and has been asserted in Louisiana as well as federal courts as evidence of insanity at time of commission of a crime. To the author's knowledge, it has not yet been successful in Louisiana. *State v. Felde*, 422 So. 2d 370 (La. 1982); *State v. Jackson*, 880 So. 2d 841 (La. App. 5th Cir. 2004).

Battered Women's Syndrome has similarly been used as evidence for an insanity defense but again, to the author's knowledge, it has not been successful. *State v. Schultz*, 817 So. 2d 202 (La. App. 5th Cir. 2002).

Multiple Personality Disorder: When there is evidence of a multiple personality disorder (MPD), two approaches have been recognized for determining whether the MPD supports an insanity defense. There is the global approach, which recognizes insanity when the core personality is not in control of commission of the offense and therefore unable to appreciate the wrongfulness of the conduct of the alter, and the specific alter personality approach which only recognizes insanity when the alter in control at time of commission of the offense did not recognize right from wrong. *United States v. Denny-Schaffer*, 2 F.3d 999 (10th Cir. 1993). Louisiana has yet to rule on an approach.

Schizophrenia: Schizophrenia is a disorder that often causes disconnect from reality and can prevent someone suffering from it to lose the ability to distinguish right and wrong. *State v. Currie* is a good example of a case where a schizophrenic teen committed murder while in a trance-like state. Here the appellate court stated it "could not imagine a case wherein an insanity defense could possibly be more

strong." 812 So. 2d 128, 138 (La. App. 4th Cir. 2002).

Q: Is Not Guilty by Reason of Insanity the same issue as Competency to Stand Trial?

A: **No**. The insanity defense looks at the defendant's mental state at time of commission of the crime to determine whether it precludes criminal responsibility. Competency to stand trial looks at the defendant's current mental state in order to ascertain whether he is able to understand the proceedings brought against him or assist in his own defense, so as to allow a fair trial. A client can be incompetent to stand trial but not have a NGRI defense, and vice versa. Although legally distinct, when competency is an issue both should be evaluated.

Q: Can evidence of a mental defect short of insanity be used to negate the requisite specific intent or reduce the degree of a crime?

A: **Yes and No**. **There is no diminished capacity defense in Louisiana.** *State v. Pitre*, 901 So.2d 428, 444, (La. App. 1st Cir.12/17/04), *writ denied,* 902 So.2d 1018, (La.5/13/05).*State v. King*, 799 So.2d 1241(La. App. 3rd Cir. 2001), *writ denied,* 825 So.2d 1190 (La. 2002); Lousiana Code Crim. P. art. 651. Evidence of mental condition is only admissible to determine whether the defendant was insane at the time of the commission of the crime. It may not be considered to determine if the defendant had the requisite *mens rea*, e.g. between 2nd degree murder and manslaughter; and it may not be considered to determine if the defendant perceived a threat when self-defense is asserted. The United State Supreme Court has said that due process is not violated by limiting or precluding the use of a diminished capacity defense; and as with all other crimes and affirmative defenses each state is permitted to create or limit them as it sees fit. *Clark v. Arizona*, 548 U.S. 735 (2006).

However, the court can consider observation evidence: testimony from those who observed what the defendant did, heard, said, or an expert who can testify as to a defendant's tendency to think a certain way and his behavioral characteristics. *Id.* at 757, 760. This type of evidence can be presented by either lay or expert witnesses. *Id.* at 758. It can help to support a professional diagnosis of mental disease and can help show what was on the defendant's mind when they committed the act. *Id.* at 757. This type of testimony is admissible to rebut the prosecution's proof of *mens rea*. *Id.* at 760.

Q: Can evidence of a mental defect be introduced to show that my client could not control his behavior?

A: **No. There is no irresistible impulse defense in Louisiana.** *State v. Johanson*, 332 So. 2d 270 (La. 1976); *State v. Daigle*, 344 So. 2d 1380 (La. 1977).

The Louisiana Supreme Court in *State v. Jones*, 359 So.2d 95 (1978), noted that although there was no diminished capacity defense in Louisiana, the majority of states considered evidence of mental condition, short of insanity, to be relevant and admissible to negate premeditation or deliberation, or in other words, to prove diminished capacity. The *Jones* Court then quoted a legal treatise in which this more liberal view is referred to as "the better view." *Id* at 98. Although the Court was unwilling to create a judicial diminished capacity defense, it seems that the Louisiana Supreme Court, at least back in 1977, would have supported the legislative passage of this defense.

Who:

Q: Who can raise the issue of insanity?

A: **The defense**. The insanity plea may be raised as a dual plea of not guilty and not guilty by reason of insanity. If the defense fails to enter a plea of insanity, then no evidence of insanity or mental defect at the time of the offense will be admitted at trial. Louisiana Code Crim. P. art. 651.

Note: **Failure to investigate insanity defense, when it is a possible issue, may constitute ineffective assistance of counsel.** If there is indication that the defendant may have an insanity defense, then you have an obligation to further investigate and evaluate the viability of this defense. *Strickland v. Washington*, 466 U.S. 668 (1984). Failure to do so can be ineffective assistance of counsel. *Beavers v. Balkcom*, 636 F.2d 114 (5th Cir. 1981).

Note: One study found **NGRI acquittees actually spend almost double the amount of time that defendants convicted of similar charges spend in confinement**. Joseph H. Rodriguez, Laura M. LeWinn, & Michael L. Perlin, *The Insanity Defense Under Siege: Legislative Assaults and Legal Rejoinders*, 14 Rutgers L.J. 397, 401-02 (1983).

Q: Can the insanity defense be imposed over a defendant's objections?

A: By Courts

Probably Not. While Louisiana courts have not taken a stance on the issue, most circuits now hold that so long as the defendant intelligently and voluntarily waives the defense of insanity it cannot be imposed by the trial court. *Frendak v. United States*, 408 A.2d 364, 380 (D.C. App. 1979); *United States v. Marble*, 940 F.2d 1543, 1548 (D.C. Cir. 1991). The U.S. Supreme Court originally accepted the premise that the insanity defense could be imposed in *Lynch v. Overholser*, 369 U.S. 705 (1962) but did not indicate scenarios where it is proper to do so. A later case coming out of the District of Columbia, *Frendak v. United States*, 408 A.2d 364 (D.C. App. 1979), declined to follow prior cases in that circuit allowing imposition of the defense in light of recent Supreme Court opinions that expanded the rights of a competent defendant to choose his plea, direct his defense, or forego representation by counsel. *Faretta v. California*, 422 U.S. 806 (1975); *North Carolina v. Alford*, 400 U.S. 25 (1970).

The insanity defense can be imposed *sua sponte* where a defendant cannot intelligently and voluntarily waive the defense. When evidence suggests insanity at the time of the crime is an issue, then the court must inquire as to the competency of the waiver. It is not appropriate to simply rely on a finding of competence to stand trial. *Frendak v. United States*, 408 A.2d 364 (D.C. App. 1979).

A: By Counsel

No. When a *competent* defendant wishes to plead guilty rather than not guilty by reason of insanity, and he clearly understands the consequences of his choice, then counsel must acquiesce. *State v. Lowenfield*, 495 So. 2d 1245, 1252 (La. 1986). The NGRI plea has serious consequences, such as possibly longer confinement than a plea of guilty would result in and societal stigma. For these reasons and in consideration of a competent client's right to make defense decisions, most scholars and courts agree that a client's decision not to plead NGRI should be respected unless there are compelling ethical obligations, such as a strong belief the client is not intelligently and voluntarily waiving the plea. Christopher Slobogin & Amy Mashburn, *The Criminal Defense Lawyer's Fiduciary Duty to Clients with Mental Disability*, 68 Fordham L. Rev. 1581 (2000). In these scenarios, the defense counsel can address the issue to the court and leave the decision to impose the insanity defense to it. Of course, this may create a conflict between counsel and client.

But beyond investigation, the insanity defense falls into the category of defense decisions that are within the defendant's control. *Faretta v. California*, 422 U.S. 806 (1975).

When:

Q: When should the insanity defense be raised?

A: **Within 10 days after arraignment or any time prior to trial with showing of good cause**. La. Code Crim. P. art. 561. Failure of the court to allow a change of plea on the day of the trial, when good cause was shown, can be reversible error. *State v. Delpit*, 341 So. 2d 876 (La. 1977); *State v. Taylor*, 254 La. 1051, 229 So. 2d 95 (La. 1970). In *State v. Miller*, 964 So.2d 911 (La. 2007), the Louisiana Supreme Court held that Art. 561 "good cause" is shown when the defendant produces an *indicia* of insanity and shows that the delay in the plea is neither due to dilatory tactic nor an attempt to gain a strategic advantage. An indicia of insanity at the time of the offense cannot be the sole determinative factor in deciding whether a defendant may change their plea under La. Code Crim. P. art. 561. *Miller*, 964 So.2d at 923.

Procedures After a Plea of Not Guilty and Not Guilty By Reason of Insanity Has Been Entered

Appointment of Sanity Commission- La. Code Crim. P. art. 650

Time of Sanity Commission appointment — When the defendant enters the dual plea of not guilty and not guilty by reason of insanity, the court **may** appoint a Sanity Commission to make an examination as to the defendant's mental condition at the time of the offense, as provided in La. Code Crim. P. arts. 644–646 governing incompetence to stand trial. The court may order the Sanity Commission to inquire into both capacity to stand trial and insanity at time of commission of the offense.

Note: **The appointment of a Sanity Commission is discretionary with the court.** The code article states "The court ***may*** appoint a Sanity Commission." Whether a Sanity Commission is appointed to investigate the defendant's sanity at time of commission of a crime is within the discretion of the trial judge, and a defendant is not entitled of right to such appointment. *State v. Link*, 301 So. 2d 339 (La. App. 4th Cir. 1974); *State v. Taylor*, 347 So. 2d 172 (La. 1977). The defense can present an ex parte motion for appointment of a Sanity Commission. *Ake v. Oklahoma*, 470 U.S. 68 (1985). Judges take into account lay testimony, evidence of past mental illness, and their own observations in deciding whether there are reasonable grounds to believe insanity at the time of the offense is an issue warranting appointment of a Sanity Commission.

Practice Point:

In order to persuade the judge that reasonable grounds exist to appoint a Sanity Commission, you should provide specific, credible evidence which supports the concern that your client has a viable insanity defense. This evidence may take the form of an affidavit or testimony - yours, jail staff, an expert, family, treating mental health professional or any other person who would have information relevant to your client's mental state at the time of the offense. You may also want to present medical records or other documentation establishing the nature and extent of your client's mental illness. Remember, you do ***not*** need to provide the court with evidence about your client's *present* mental condition for NGRI defense purposes, but rather evidence that supports a viable NGRI defense for the time of the offense.

Composition of the Sanity Commission is governed by the Competency to Stand Trial Statutes - La. Code Crim. P. art. 644–646. The Sanity Commission shall consist of two or three members. The members must be physicians who have practiced medicine in Louisiana for at least the three consecutive, preceding years. One member may be a clinical psychologist meeting the above requirements and with training or experience in forensic evaluations. One member of the commission must be a psychiatrist, unless unavailable in which case one must be a clinical psychologist, and no more than one member may be the coroner or one of the coroner's deputies. La. Code Crim. P. art. 644(A).

Mental health team unit in lieu of Sanity Commission — In a judicial district that has entered into an agreement for evaluation services with a local mental health unit team, the court may appoint the local unit to examine and report on the mental health of the defendant in lieu of the Sanity Commission. La. Code Crim. P. art. 644 (D)(1).

Note: **Defendant or State may have an independent expert.** The defendant or the state is entitled to conduct an independent examination by a mental health professional. La. Code Crim. P. art 646. Additionally, an indigent defendant who enters a viable insanity plea is entitled to the appointment of an expert to assist him in that defense. *Ake v. Oklahoma*, 470 U.S. 68 (1985). Failure of the court to do so, when such assistance is requested, constitutes reversible error. *State v. Hamilton*, 441 So. 2d 1192 (La. 1983). Independent psychiatric experts can be extremely useful for your client's case to either verify the findings of the Sanity Commission, help you interpret the findings or contest their validity; so consider utilizing this right to an outside expert.

Preparing your client for the Sanity Commission Examination — Explain to your client in advance that they will be meeting with doctors, and should provide full cooperation. Explain that if he does not understand a question he should say so and not answer it. Explain that the conversation will NOT be confidential, and could be brought up at trial on the issue of his insanity. Explain the reason for the doctors examining him and the possible outcomes -- either the Sanity Commission will support the plea of NGRI or not.

Note: **Defense counsel does not have a right to be present during the examination.** This is true because the courts have found that the insanity/competency examination is not a "critical stage of proceedings." *State v. Breaux*, 337 So.2d 182 (La. 1976); *State v. Jones*, 359 So. 2d 95 (La. 1978). **However, you may request to be present** at the Sanity Commission evaluation, and it is advisable to do so.

Consider providing supporting information to Sanity Commission — It may be helpful to provide the Sanity Commission or your independent expert with background information on your client that is helpful to his case. This could include prior medical or psychiatric records, school records, or disability records, as well as oral or written testimony of those who know the defendant and his mental state at the time of commission of the crime. Keep in mind any records you provide become part of the court record and will be available to the State.

The Sanity Commission report — Within 30 days of its appointment, the Sanity Commission is required to file its report with the judge. "The clerk shall make copies of the report available to the district attorney and to the defendant or his counsel without cost." La. Code Crim. P. art. 645(B). The report must discuss your client's mental state at the time of commission of the crime.

Part C. The Trial: Not Guilty & Not Guilty by Reason of Insanity

Introduction

***First*: State must prove beyond a reasonable doubt every element of the offense (all normally available defenses are available e.g. self-defense, alibi, etc.).**

***Second*: Defense must prove insanity by a preponderance of the evidence.**

The defense of insanity becomes available upon entry of the plea of not guilty and not guilty by reason of insanity. The jury must first decide whether the defendant committed the offense charged; then if this is found the defendant must establish his insanity defense to escape culpability. *State v. Marmillion*, 339 So. 2d 788 (La. 1976). All defenses available under the law *are* permitted, such as evidence the defendant did not commit the offense charged or he was justified by self-defense.

Practice Point:

It is important to remember that unless the dual plea has been entered, evidence of insanity or a mental defect at the time of the offense may not be admissible. La. Code Crim. P. art. 651. However, the U.S. Supreme Court has stated that observation evidence (such as what the defendant did, heard or said, or an expert's testimony as to a defendant's tendency to think a certain way, or their behavioral characteristics) is admissible to negate specific intent. *Clark v. Arizona*, 548 U.S. 735, 760 (2006).

Burden of Proof — Presumption of sanity is overcome by a preponderance of the evidence. A legal presumption exists that the defendant was sane at the time of commission of the offense. *State v. Silman*, 663 So. 2d 27, 32 (La. 1995); La. R.S. 15:432. To rebut the presumption, the defendant has the burden of establishing the defense of insanity at time of commission of the offense by a ***preponderance of the evidence.*** Defendant need not prove insanity beyond a reasonable doubt - instructing the jury as such is reversible error.

Q: Is shifting the burden of proof to the defendant for NGRI constitutional?

A: YES. The U.S. Supreme Court held it constitutional to place the burden of proving the defense of insanity on the defendant. *Leland v. Oregon*, 343 U.S. 790 (1952). This has been upheld as not (1) relieving the state from its burden of proving the elements of the offense or (2) infringing on the presumption of innocence. *State v. Thompson*, 429 So. 2d 862 (La. 1983).

The state may rely on the defense not meeting its burden, or the state may introduce evidence to contradict the affirmative defense of insanity. The state need not assert evidence of sanity to rebut a claim of insanity, as it can rest on the defendant's failure to prove insanity by a preponderance of the evidence. However, they may affirmatively challenge the defense case by introduction of expert or lay testimony. *State v. Thames*, 681 So. 2d 480, 486 (La. App. 1st Cir. 1996).

Testimony and Evidence:

Sanity Commission Members may testify: Any member of the Sanity Commission can be called as witnesses by the court, defense, or district attorney. Regardless of who calls them, they will be subject to cross examination by the defense, DA, or court. Any other evidence pertaining to the defense of insanity may be introduced by the defense and the DA. La. Code Crim. P. art 653.

Note: Insanity is a question for the jury (or judge if the judge is the fact finder). The determination of the defendant's ability to distinguish between right and wrong at the time of commission of the offense is a question of fact for the jury, whereas the determination of capacity to stand trial is a question for the judge. *State v. Link*, 301 So. 2d 339 (La. 1947). Accordingly, **any conclusory opinions of experts as to the question of the understanding between right and wrong should be avoided.** *United States v. Chandler*, 393 F.2d 920, 926 (4th Cir. 1968).

Q: What effect should be given to expert testimony?

A: Although weighing the evidence is within the fact finder's purview, **opinions of experts cannot be arbitrarily ignored**; there must be some objective reason for rejecting their testimony. *Perez v. Cain*, 529 F.3d 588, 595 (5th Cir. 2008). Expert testimony can be rebutted, "by showing the incorrectness or inadequacy of the factual assumptions on which the opinion is based, the reasoning by which he progresses from his material to his conclusion, the interest or bias of the expert, inconsistencies or contradictions in his testimony as to material matters, material variations between the experts themselves, and defendant's lack of co-operation with the expert." *Mims v. United States*, 375 F.2d 135, 143-44 (5th Cir. 1967). **Failure to take into account unanimous expert testimony of the defendant's insanity with no rational basis for doing so can result in reversal of a guilty verdict.** *Perez v. Cain*, 529 F.3d at 595 ("[S]ome reason must be objectively present for ignoring expert opinion testimony.").

Lay testimony concerning the defendant's conduct is admissible: Lay testimony of the defendant's actions before or after the offense may provide the fact finder with a rational basis for rejecting a unanimous medical opinion that the defendant was legally insane at the time of the crime. *State v. Claibon*, 395 So. 2d 770, 774 (La. 1981); *State v. Perez*, 745 So. 2d 166, 181 (La. App. 4th Cir. 1999).

Q: Can the defense prevent testimony of the Sanity Commission based on the doctor-client privilege?

A: No. A plea of NGRI waives the defendant's claim of doctor-patient privilege as to any medical or psychiatric reports and testimony relevant to determination of the defendant's insanity at time of commission of the crime. *State v. Berry*, 324 So. 2d 822, 827 (La. 1975).

Exception: Inculpatory statements made to Sanity Commission are not admissible except for impeachment purposes. Inculpatory statements made to the Sanity Commission are not admissible as evidence of a defendant's guilt or innocence and should not be included in the Sanity Commission report. *State v. Koon*, 704 So. 2d 756 (La. 1997). However, statements made to the Sanity Commission are admissible for impeachment purposes, even in the absence of *Miranda* warnings. *Felde v. Blackburn*, 795 F.2d 400, 404 (5th Cir. 1986).

Jury Instructions

Upon defendant's request, the jury must be instructed as to the consequences of a NGRI verdict. In Louisiana courts, at the defendant's request the jury MUST be instructed of the consequences of a not guilty by reason of insanity verdict. *State v. Babin*, 319 So. 2d 367, 379-81 (La. 1975) (on reh'g). This is a critical jury instruction that federal courts and many other jurisdictions do not allow. *Shannon v. U.S.*, 512 U.S. 573 (1994); *Diestel v. Hines*, 506 F.3d 1249 (10th Cir. 2007), **cert. denied**, 553 U.S. 1079 (2008). In *Diestel*, the Supreme Court denied cert. and let the Tenth Circuit's decision stand, holding that the trial court's failure to instruct the jury on the consequences of a verdict of NGRI did not violate the defendant's constitutional right to a fair trial. There are many misconceptions about NGRI, and one is that those acquitted on the charge will immediately be released back into society. This could cause many jurors to shy away from finding a defendant NGRI even if they believe the defendant fits the charge, as they fear he is still a danger to society. **Be sure to request this as a jury instruction;** it will work to your client's advantage.

The jury instructions to be read at the defendant's request where the insanity defense has been raised are below. Additionally, the court may, at defense counsel's request, permit more detailed instruction. See *State v. Watkins*, 340 So. 2d 235 (La. 1976).

Jury Instructions to be Read Upon Defense Request:

Cheney C. Joseph, Jr. & P. Raymond Lamonica, *17 La. Civ. L. Treatise: Criminal Jury Instructions and Procedures, § 6.03, Legal Effect of Verdict of Not Guilty by Reason of Insanity – Capital Cases* (2d ed., Thomson West 2003).

If a verdict of not guilty by reason of insanity is returned in this case, the court will commit the defendant to a proper state mental institution or to a private mental institution approved by the court for custody, care and treatment.

The defendant shall not be released until the court determines that he can be released without danger to himself or to others.

Id. § 6.02, Legal Effect of Verdict of Not Guilty by Reason of Insanity – Non Capital Felony Cases

If defendant is found not guilty by reason of insanity in this case, the court will remand him to the parish jail or to a private mental institution approved by the court. The court will promptly hold a hearing. The district attorney will represent the state and participate in the hearing. (At the hearing, the defendant will have the burden to show by a preponderance of the evidence that he can be discharged

or can be released on probation, without danger to others or to himself.)

If the court determines that the defendant can be discharged or can be released on probation, without danger to others or to himself, it shall either order his discharge, or order his release on probation subject to specified conditions for a fixed or an indeterminate period.

If the court determines that the defendant cannot be released without danger to others or to himself, the court shall order him committed to a proper state mental institution or to a private mental institution approved by the court for custody, care, and treatment.

If committed, the defendant shall not be released until the court determines that he can be released without danger to himself or to others.

Part D. Acquittal on the Grounds of Insanity

If your client is found not guilty by reason of insanity, depending on whether the case was capital or not, the defendant shall either be instantly committed to a mental institution or a hearing, known as the initial dangerousness hearing, will be held to determine whether he should be committed, released or released on probation. It is important to remember the insanity acquittee has not been convicted; rather his detention continues solely for his treatment.

Capital Cases:

If your client is found not guilty by reason of insanity in a capital case, **he shall be committed to a proper mental institution for his custody, care, and treatment**. La. Code Crim. P. art. 654.

Non-Capital Cases:

For all other felony cases, the court shall **remand the insanity acquittee to the parish jail or a private mental institution** approved by the court while he awaits a prompt contradictory hearing, known as the initial **dangerousness hearing**. La. Code Crim. P. art 654.

Initial Dangerousness Hearing Following NGRI Acquittal:

The court will hold a prompt contradictory hearing to determine whether the insanity acquittee can be released without danger to himself or others. La. Code Crim. P. art 654. **Issue at hearing = is defendant dangerous?**

If yes, then commitment; if no, then release.

At the *initial* hearing, the court does not need to consider whether or not the defendant is mentally ill. The U.S. Supreme Court in *Jones* explained that implicit in the NGRI acquittal is a finding that the defendant is mentally ill and thus the **only issue before the court, when determining if commitment is appropriate, is whether the defendant is dangerous**. *Jones v. United States* 463 U.S. 354, 363-66 (1983).

The burden of proof (at the initial hearing) **is on the defendant, to prove that he is not a danger.** La. Code Crim. P. art. 654.

However, **if there has been a long passage of time** between the time of the offense and the initial commitment hearing, the *Jones* Court reasoning would not apply. Accordingly**, it may be worth challenging the presumption** of mental illness in those situations. *Francois v. Henderson*, 850 F.2d 231, 236 (5th Cir. 1988) (dicta suggesting that presumption of mental illness and confinement solely on finding of dangerousness may be unconstitutional); *State v. Perez*, 563 So. 2d 841, 846 (La. 1990) (Dennis, J. dissenting, "Due process will not permit a state to commit or continue to confine someone, civilly or criminally, without proof that he is both mentally ill and dangerous to himself or to society…. The propensity for danger alone is not sufficient constitutional basis for the confinement of a person not mentally ill in an insane asylum.").

Note: **The *Jones* Court presumption** that after an NGRI acquittal, the defendant may be presumed mentally ill, is **only valid for the initial hearing,** because it is close in time to the NGRI acquittal. Thus, for all subsequent hearings the State must prove both mental illness ***and*** dangerousness. *Foucha v. Louisiana*, 504 U.S. 71 (1992).

"**Dangerous to others**" means the condition of a person whose behavior or significant threats support a reasonable expectation that there is a substantial risk that he will inflict physical harm upon another person in the near future. La. R.S. 28:2(3).

"**Dangerous to self**" means the condition of a person whose behavior, significant threats or inaction supports a reasonable expectation that there is a substantial risk that he will inflict physical or severe emotional harm upon his own person. La. R.S. 28:2(4).

Caution: The *Jones* Court stated that the very fact that defendant was found beyond a reasonable doubt to have committed a criminal act *indicates* dangerousness. The Court made this statement even though the defendant in *Jones* was found to have committed misdemeanor theft.

Expert assessment regarding dangerousness is unreliable: The American Psychiatric Association (APA), while participating as amicus curiae in *Barefoot v. Estelle*, stated "the unreliability of psychiatric predictions of long-term future dangerousness is by now established within the profession." 463 U.S. 880, 920 (1983) (Blackmun, J. dissenting). The APA found that two out of three predictions of dangerousness are wrong. *Id*. Other studies have similarly found that dangerousness is a vague concept, hard to meaningfully predict, and coupled with this there exist strong pressures upon decision makers to over predict dangerousness. Bernard L. Diamond, "*The Psychiatric Prediction of Dangerousness*," 123 U. Pa. L. Rev. 439 (1974); *State v. Krol*, 68 N.J. 236, 344 A.2d 289 (1975).

Findings: The court shall rule the insanity acquittee either dangerous or not dangerous to himself or others.

If Defendant is found Dangerous, then the court must order him committed to a proper mental institute for care and treatment.

Note: Studies show that the average death rate among resident mental patients far exceeds that of the general U.S. population. One study found that while the death rate per 1,000 people in the general population is only 9.5 each year, the rate among resident mental health patients is 91.8. Marian Schwalm Furman & James A. Conners, Jr., *The Pennsylvania Experiment in Due Process*, 8 Duq. L. Rev. 32, 65-66 (1970).

If the defendant is found not dangerous, then the court shall order the acquittee's discharge, with or without conditional release (also known as probation, La. Code Crim. P. art. 658), for a fixed or

indeterminate period. The judge must issue written reasons for his decision. Conditional release is discussed in the next section.

Proceedings to Determine Release After Commitment

If the defendant has been committed under La. Code Crim. P. art 654, having been found dangerous and presumed mentally ill based on the finding of NGRI, the acquittee then begins the process of applying for discharge or conditional release.

To obtain a contradictory hearing on the issue of Discharge or Conditional Release	
First	The superintendent of the mental institution recommends defendant's discharge or conditional release.
Second	The review panel, consisting of the treating physician, the facility's clinical director, and a member of the Sanity Commission which recommended commitment of the acquittee, concurs; La. Code Crim. P. art. 655(A).
Then	A contradictory hearing shall be held.
— OR —	
First	After six months, the defendant may make an application to the review panel for discharge. La. Code Crim. P. art. 655(B).
Second	The review panel recommends release.
Then	A contradictory hearing shall be held.

If the review panel does not recommend release, the acquittee cannot make another application for release to the panel for one year.

In either scenario, the superintendent shall transmit a copy of the report and recommendation to the committed person or his attorney and the DA of the parish in which he was committed.

Note: The committed person or the DA may also retain a psychiatrist to examine the committed person, independent of the review panel, to present findings to the judge at the contradictory hearing.

The Pre-Release Contradictory Hearing:

At the contradictory hearing, the burden is on the ***State*** to prove by ***clear and convincing evidence*** that the insanity acquittee is **both mentally ill AND dangerous** if it wishes to seek continuance of confinement. La. Code Crim. P. art. 657.

Compare: Whereas for initial commitment the finding of NGRI provides an assumption of insanity, when an application is made for release, that assumption no longer exists and the burden shifts to the state to prove insanity and dangerousness.

Note: In *Foucha v. Louisiana*, 504 U.S. 71 (1992), the U.S. Supreme Court found Louisiana's post acquittal proceedings unconstitutional in that they allowed continued commitment of an acquittee on the basis of dangerousness alone, despite no present existence of a mental illness. The Supreme Court held that once the mental illness or the dangerous behavior is gone, the state's rationale for detention of the acquittee is gone as well. Louisiana's Code of Criminal Procedure has been revised to reflect this standard.

Q: Are the current Louisiana code provisions for release of insanity acquittees now constitutional?

A: **Arguably not.** Louisiana's insanity acquittee release procedures still implicate constitutional concerns. *Foucha* ruled it constitutional for insanity acquittees to be treated under a different standard for initial commitment than people civilly committed (the state need not prove by clear and convincing evidence the person being committed is mentally ill and dangerous) but not when it comes to release proceedings. 504 U.S. at 76-80. Here, the insanity acquittee is entitled to the same proceedings as used for civil commitment because the state's initial grounds for holding the individual as an insanity acquittee no longer exist (evidence shows he is no longer mentally ill or dangerous).

Louisiana criminal commitment statutes do not match up with our civil commitment proceedings. Release from criminal commitment requires either the superintendent or the insanity acquittee to petition the review panel for discharge which can recommend, after finding acquittee is not a danger to himself or others, to the court that the person be discharged conditionally or unconditionally or placed on probation If this recommendation is made, the court shall conduct a contradictory hearing on the matter. La. Code Crim. P. art. 655(A). In civil commitment, however, review of the commitment to determine dangerousness is required every 180 days. La. R.S. 28:56. In addition, civil commitment provides for conditional release for a period of 120 days, with an option for an extension of 120 days upon application by the director of the treatment facility to the court. Any additional extension will not be granted without a contradictory hearing. La. R.S. 28:56(G). In contrast, criminal commitment allows for the conditional discharge of the acquittee for a "fixed or an indeterminate period." La. Code Crim. P. art. 657.

Unlike those civilly committed, the insanity acquittee has no automatic right to review of his commitment, or to an end to conditional release. The continued different treatment in Louisiana of those criminally committed from those civilly committed, after the point of initial commitment, is arguably unconstitutional.

Q: Can an acquittee be detained longer than they would have if they had been found guilty?

A: **Yes**. An NGRI acquittee may be detained indefinitely provided he is both mentally ill and dangerous, even if that detention exceeds the maximum sentence he would have received if found guilty. *Jones v. United States*, 463 U.S. 354, 368-69 (1983); *Foucha v. La.*, 504 U.S. 71, 76 n. 4 (1992).

Note: **Insanity acquittees DO generally spend more time confined than convicted defendants.** For example, in New York, insanity acquittees were confined on average 1729 days while guilty defendants were confined 819 days. Similarly, in California, acquittees were confined an average of 1359 days while the guilty spent 610 days confined. Morris, *Placed in Purgatory: Conditional Release of Insanity Acquittees*, 39 Ariz. L. Rev. 1061, 1063 (1997).

Q: What is the rationale behind treating insanity acquittees as a "separate class" for initial commitment, but not for subsequent release proceedings?

A: 1. NGRI acquittees are less likely to need protection from wrongful commitment and;

2. They have committed an act that constitutes a crime.

The Supreme Court case of *Jones v. United States.* 463 U.S. 354 (1983), articulates the reasoning behind the automatic assumption of mental insanity for the purpose of initial commitment and the different standard of proof for a finding of insanity. It held that there are, "important differences between the class of potential civil-commitment candidates and the class of insanity acquittees that justify differing standards of proof." *Id.* at 367. The court pointed to the fact that standards for civil commitment are intended to prevent wrongful commitment, which is less common in NGRI because the defendant advanced the theory. Also, NGRI establishes that the defendant committed a crime whereas those civilly committed have not. *Id.*

Reading *Foucha* and *Jones* together, it would seem that for initial commitment, currently it is constitutional for insanity acquittees to be treated as a separate class from those civilly committed, because they have committed a criminal act and were found mentally ill at the time of its commission, but for subsequent release proceedings insanity acquittees must receive the same constitutional safeguards as those civilly committed because evidence supports that they are no longer mentally ill and/or dangerous.

Conditional Release:

When there has been a recommendation by the review panel for discharge or release on probation, the court may place the acquittee on conditional release if it finds a variety of factors met, such as the need for outpatient monitoring, the existence of appropriate outpatient monitoring, and *no risk of danger to others or self*. La. Code Crim. P. art. 657.1. The court will decide what conditions of probation are necessary for both the acquittee's and society's interests. Conditional release must extend at least one year but not more than five, although it can be extended after five years in one year increments for good cause shown at a yearly contradictory hearing. La. Code Crim. P. art. 657.2.

Q: Can a defendant who is no longer mentally ill due to drug treatment be eligible for release?

A: **Yes**. If the defendant is at risk of reverting to insanity in the event he discontinues taking medication, this does not necessarily make him ineligible for conditional release. *State v. Perez*, 648 So. 2d 1319 (La. 1995) (finding where there was no indication defendant would stop taking medication, he had completed periods of probation, and could be quickly reincarcerated if problems developed, conditional release could be granted).

Q: Is it constitutional to put insanity acquittees on conditional release?

A: Though in theory a conditional release period is designed to ease an acquittee back into the community setting while still providing adequate protection for the public, some question whether conditional release has just become a means of extending punishment when the state can no longer legally confine an acquittee. "[D]ue process requires that the nature and duration of commitment bear some reasonable relation to the purpose for which the individual is committed." *Jackson v. Indiana*, 406 U.S. 715, 738 (1972). For insanity acquittees, the purpose of commitment is treatment of their mental illness and dangerousness in a non-punitive manner. When either dangerousness or mental illness ceases to exist, the State loses its interest in commitment.

However, to be eligible for conditional release the acquittee must no longer be mentally ill or dangerous. La. Code Crim. P. 657; 657.1. It can be said the State's continuing control over the insanity acquittee, which includes mandating where he lives, what medications he takes, and the ability to revoke conditional release for sometimes arbitrary reasons, makes conditional release punitive because the State's rehabilitative purpose no longer exists. Maura Caffrey, *A New Approach to Insanity Acquittee Recidivism: Refining the Class of Truly Responsible Recidivists,* 154 U. Pa. L. Rev. 399 (Dec. 2005). To punish in this manner violates due process because the commitment is no longer related to the purpose for commitment. *Jackson v. Indiana*, 406 U.S. 715, 738 (1972). ("[D]ue process requires that the nature and duration of commitment bear some reasonable relation to the purpose for which the individual is committed.")

As further evidence of the punitive nature of conditional release, studies show the period of conditional release is longer for those charged with more severe crimes, such as homicide. Grant H. Morris, *Placed in Purgatory: Conditional Release of Insanity Acquittees,* 39 Ariz. L. Rev. 1061, 1064 (1997). This shows that courts are being influenced by the nature of the charge and punishing those with more serious charges despite the fact the acquittee was not convicted of the crime. As the court in *Jones* summed up: "[Because the acquittee] was not convicted, he may not be punished…There simply is no necessary correlation between severity of the offense and length of time necessary for recovery." *Jones v. United States*, 463 U.S. 354, 369 (1983).

Recommitment:

If the person released on conditional release becomes a danger to himself or others due to mental illness, substance abuse, or mental retardation, he shall be recommitted. La. Code Crim. P. art. 658(A).

Violation of Conditional Release:

The insanity acquittee on conditional release is placed under the supervision of the division of probation and parole. When the acquittee violates or is about to violate a condition of his conditional release, he may be arrested and detained under the provisions of Article 899, which governs those on general probation. La. Code Crim. P. 658 (B)(1). The court shall be notified of violations and receive a recommendation from the conditional release program coordinator as to whether the probation should be revoked or the insanity acquittee recommitted. The court, on its own motion or that of the district attorney or probation officer, can order the acquittee arrested in order to hold a hearing on the violation. La. Code Crim. P. art. 658(B)(6).

> If the court determines that there has been a violation or that the probationer was about to violate the conditions of release or probation it may do any of the following:
>
> (1) Reprimand and warn the probationer.
>
> (2) Order that supervision be intensified.

(3) Modify or add additional conditions to the probation.

(4) Revoke the probation and recommit the probationer to a state mental institution, subject to consideration for discharge or release on probation only after one year has elapsed from the date of revocation and in accordance with the procedure prescribed in Articles 655 through 657 for a first application and hearing. La. Code Crim. P. art. 658(C).

Q: Are the consequences of violating conditional release constitutional?

A: **Arguably, no.**

Foucha v. Louisiana, 504 U.S. 71 (1992), confirms the principle that insanity acquittees can only be detained while they have a mental illness and are dangerous to themselves or others. When either condition ceases, so does the State's rights to confine them as acquittees, and any further deprivation of liberty must meet the same constitutional standards as provided for standard civil commitment.

However, revocation of conditional release for NGRI acquittees differs drastically from that for Title 28 civil committees.

If conditions of **Title 28 conditional release** are violated**,** then the committee is, "subject to any of the procedures for **involuntary treatment**." La. R.S. 28:56(G)(3). Involuntary treatment can allow for an order of custody or issuance of an emergency certificate. *Id*. When an order of custody is made, a **peace officer delivers the person to a treatment facility** designated by the court. La. R.S. 28:54 (D)(3). If there is cause to detain the person, the treatment facility is authorized to do so **until the commitment hearing** is completed. *Id.* If an emergency certificate is issued, the person can only be detained 72 hours before the facility either releases or begins commitment proceedings. La. R.S. 28:53(F)(2);(M).

If conditions of **NGRI conditional release** are violated, then **code provisions for violation of probation apply**. Pursuant to La. Code Crim. P. art. 658(B)(1), if the defendant violates or is about to violate conditional release then article 899 (which governs probation violators) **allows for the acquitee's arrest and incarceration** pending a probation violation hearing.

The NGRI acquittee had to no longer be dangerous in order to qualify for conditional release in the first place. This means that the *Foucha* court's rule applies – the acquittee may only be under NGRI commitment if dangerous and mentally ill. To be placed on conditional release requires the acquittee be found not dangerous. Revocation of conditional release and recommitment should thus require a new finding that the acquittee is both mentally ill and dangerous, as civil commitment does. Grant H. Morris, *Placed in Purgatory: Conditional Release of Insanity Acquittees,* 39 Ariz. L. Rev. 1061, 1112 (1997).

Discharge from Conditional Release:

The court can completely discharge an acquittee from conditional release, "after the expiration of one year in a supervised conditional release program only on recommendation of the director of the division of probation and parole or the administrator of the conditional release program or on other proper evidence of expected outpatient compliance with any continued treatment recommendations, and after a contradictory hearing with the district attorney." La. Code Crim. P. art 658(D).The court may also grant an application for discharge with no probation period.

Q: Once discharged, are there any long-term effects of having an acquittal due to insanity?

A: When the court has agreed to an insanity acquittee's discharge or release on probation, it is important to remember that although the insanity acquittee was not technically "legally responsible" for his/her act, the verdict can still have repercussions. A finding of NGRI means that although the person cannot be held legally responsible, he is said to have committed the acts constituting the charge against him. *Jones v. United States*, 463 U.S. 354, 363 (1983). Thus insanity acquittees are often said to have a double stigma – being mentally ill and a criminal. The insanity acquittee will likely be forced to comply for years with harsh conditional release requirements, could face incarceration for violation of probation (despite never having been convicted), and faces a constant threat of recommitment if he becomes a danger to himself or others due to a mental illness. Additionally, the stigma of mental illness leads others to avoid employing, socializing with, renting to, or living near people with a mental disorder, which impacts the acquittee's ability to reintegrate normally into society. Dep't of Mental Health & Human Servs., Mental Health: A Report of the Surgeon General 5 (1999), available at http://www.surgeongeneral.gov/library/mentalhealth/pdfs/c1.pdf.

Q: Does an insanity acquittee lose his voting rights from being committed or placed on conditional release?

A: **No**. The Election Code at La. R.S. 18:102 lists persons ineligible to vote: "No person shall be permitted to register or vote who is: (1) Under an order of imprisonment, as defined in R.S. 18:2(8), for conviction of a felony; or (2) Interdicted after being judicially declared to be mentally incompetent..." The Attorney General stated that insanity aquittees either currently committed or on conditional release do not lose their voting rights as they are not under order of imprisonment (commitment and conditional release are for the acquittee's care and treatment, not punishment), and while acquittees have been committed this is not equivalent to interdiction. La. Atty. Gen. Op. No. 1999-198. (Aug. 11, 1999).

Q: Are insanity acquittees charged with a sex offense required to register as sex offenders?

A: Yes. Louisiana's statute on registration of sex offenders provides, "Any adult residing in this state who has pled guilty to, has been convicted of, or where adjudication has been deferred or withheld for perpetration of any sex offense…shall register with the sheriff of the parish of each of the person's residences if there is more than one." La. R.S. 15:542. In the "Definitions" section preceding the paragraph above, "Conviction or other disposition adverse to the subject" is said to mean, "any disposition of charges, except a decision not to prosecute, a dismissal, or an acquittal, *except when the acquittal is due to a finding of not guilty by reason of insanity and the person was committed."* La. R.S. 15:541(7). The statute mandates those found NGRI where a sex offense was charged register as a sex offender. One study showed that in mid-2007, Louisiana was among 23 other jurisdictions that included NGRI acquittees among Megan's law registrants. Kenneth J. Weiss & Clarence Watson, *NGRI and Megan's Law: No Exit?*, 36 J. Am. Acad. Psychiatry Law 1, 117-22 (2008).

Yet, how can it be permissible to include NGRI acquittees among the convicted when they have

not in fact been convicted? An Arkansas case dealt with the question and found that though those found NGRI are acquitted, the verdict is based on an affirmative defense, not a lack of proof as in most acquittals. *Ark. Dept. of Correction v. Bailey*, 368 Ark. 518, 247 S.W.3d 851 (2007). The court concluded by finding the requirement of registration for those found NGRI on a sex offense is rationally related to the State's interest in protecting society from repeat sex offenders. *Id.*

If this law stands, it is important that defendants charged with sex offenses who are considering entering an NGRI plea be aware of the implications involving sex offender law. Where normally NGRI acquittees are detained until no longer mentally ill or dangerous, sex offender statutes complicate matters further as they have requirements for release and parole. See La. R.S. 15:538; R.S. 15:561.2. NGRI acquittees charged with a sex offense could face a lifetime of registering as a sex offender, being subject to electronic surveillance, and years of conditional release.

Section 4:
Common Psychiatric Drugs

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Below is a list of common psychiatric drugs that practitioners may encounter in their clients' mental health and/or medical history. The brief summary below is a non-comprehensive research summary of the name of the drug, any other common or generic names of the drug, common diagnoses associated with the drug, and where available, side effects or common physiological consequences of the drug. More detailed information should be obtained from a psychiatrist or medial doctor, as appropriate.

Bold names are the brand names of the drug.

***Italic names* are generic names of the drug.**

Information synthesized from www.drugs.com.

Additional Information:

CR following a drug name means controlled release tablets.

ER after a drug name means extended release tablets.

Abilify – *Aripiprazole* is used to treat schizophrenia. It is used alone or together with other medicines to treat mental depression and bipolar I disorder (manic-depressive illness). It is also used to treat irritability in children 6 to 17 years of age with autistic disorder. This medicine should not be used to treat behavioral problems in older adult patients who have dementia.

Adderall - *Amphetamine and dextroamphetamine* combination belongs to the group of medicines called central nervous system (CNS) stimulants. It is used to treat attention-deficit hyperactivity disorder

(ADHD) and narcolepsy (uncontrollable desire for sleep or sudden attacks of deep sleep). Amphetamine and dextroamphetamine combination increases attention and decreases restlessness in patients who are overactive, cannot concentrate for very long or are easily distracted, and have unstable emotions. It is also used as part of a total treatment program that also includes social, educational and psychological treatment.

Ambien - *Zolpidem* belongs to the group of medicines called central nervous system depressants (medicines that slow down the nervous system). Zolpidem is used to treat insomnia. Zolpidem helps you get to sleep faster and sleep through the night. In general, when sleep medicines are used every night for a long time, they may lose their effectiveness. In most cases, sleep medicines should be used only for short periods of time, such as 1 or 2 days, and generally for no longer than 1 or 2 weeks.

Anafranil - *Clomipramine* is used to treat obsessive-compulsive disorder (OCD). This medicine is a tricyclic antidepressant (TCA). OCD is a nervous condition where a person has recurring thoughts or ideas, or does repetitive things because they are anxious. Clomipramine works on the central nervous system to relieve the symptoms of OCD. It is thought to work by increasing the activity of a chemical called serotonin in the brain.

Antabuse - *Disulfiram* is used to help overcome a patient's drinking problem. It is not a cure for alcoholism, but rather will discourage one from drinking.

Campral - *Acamprosate* is used to help overcome a patient's drinking problem. It is not a cure for alcoholism, but rather will help one maintain abstinence.

Celexa - *Citalopram* is used to treat mental depression. Citalopram belongs to a group of medicines known as selective serotonin reuptake inhibitors (SSRIs). These medicines are thought to work by increasing the activity of the chemical serotonin in the brain.

Clozaril - *Clozapine* is used to treat schizophrenia in patients who have not been helped by or are unable to take other medicines. This medicine should NOT be used to treat behavioral problems in older adult patients who have dementia.

Cylert - *Pemoline* belongs to the group of medicines called central nervous system stimulants. It is used to treat children with attention-deficit hyperactivity disorder (ADHD). Pemoline increases attention and decreases restlessness in children who are overactive, cannot concentrate for very long or are easily distracted, and are emotionally unstable. This medicine is used as part of a total treatment program that also includes social, educational, and psychological treatment.

Dalmane - *Flurazepam* is used to treat insomnia. This medicine helps you get to sleep faster and sleep through the night. Flurazepam is a benzodiazepine. Benzodiazepines belong to the group of medicines called central nervous system depressants, which are medicines that slow down the nervous system.

Depakene - *Valproic acid* is used alone or together with other medicines to control certain types of seizures (convulsions) in the treatment of epilepsy. This medicine is an anticonvulsant that works in the brain tissue to stop seizures. Valproic acid is also used to treat the manic phase of bipolar disorder (manic-depressive illness), and helps prevent migraine headaches.

Depakote - *Divalproex sodium* is used alone or together with other medicines to control certain types of seizures (convulsions) in the treatment of epilepsy. This medicine is an anticonvulsant that works in the brain tissue to stop seizures. Divalproex sodium is also used to treat the manic phase of bipolar disorder (manic-depressive illness), and helps prevent migraine headaches.

Dexedrine - *Dextroamphetamine* belongs to the group of medicines called central nervous system stimulants. It is used to treat attention-deficit hyperactivity disorder (ADHD) and narcolepsy (uncontrollable desire for sleep or sudden attacks of deep sleep). Dextroamphetamine increases attention and decreases restlessness in patients who are overactive, cannot concentrate for very long or are easily distracted, and have unstable emotions. It is also used as part of a total treatment program that also includes social, educational, and psychological treatment.

Effexor - *Venlafaxine* is used to treat mental depression. It is also used to treat certain anxiety disorders or to relieve the symptoms of anxiety. However, it generally is not used for anxiety or tension caused by the stress of everyday life. Venlafaxine is also used to treat panic disorders.

Eldepryl - *Selegiline* is used in combination with levodopa or levodopa and carbidopa combination to treat Parkinson's disease (sometimes called shaking palsy or paralysis agitans). This medicine works to increase and extend the effects of levodopa, and may help to slow the progress of Parkinson's disease.

Equetro - *Carbamazepine* is used to control some types of seizures in the treatment of epilepsy. It is also used to relieve pain due to trigeminal neuralgia (tic douloureux). It should not be used for other more common aches or pains. It can also be used in the treatment of bipolar disorder (manic-depressive illness).

Eskalith - *Lithium* is used to treat mania that is part of bipolar disorder (manic-depressive illness). It is also used on a daily basis to reduce the frequency and severity of manic episodes. Manic-depressive patients experience severe mood changes, ranging from an excited or manic state (e.g., unusual anger or irritability or a false sense of well-being) to depression or sadness. It is not known how lithium works to stabilize a person's mood. However, it does act on the central nervous system. It helps patients have more emotional control.

Geodon - *Ziprasidone* is used to treat symptoms of psychotic disorders, such as schizophrenia, mania, or bipolar disorder. This medicine should not be used to treat behavioral problems in elderly patients who have dementia.

Haldol (Decanoate) - *Haloperidol* is used to treat nervous, emotional, and mental conditions (e.g., schizophrenia). It is also used to control the symptoms of Tourette's disorder. This medicine should not be used to treat behavior problems in older adult patients who have dementia. Haloperidol is also used to treat severe behavioral problems (e.g., aggressive, impulsive behavior) or hyperactivity in children who have already been treated with psychotherapy or other medicines that did not work well.

Invega - *Paliperidone* is used to treat the symptoms of psychotic disorders, such as schizophrenia. It may be used alone or together with other medicines to treat patients with schizoaffective disorder. This medicine should not be used to treat behavioral problems in older adult patients who have dementia.

Klonopin - *Clonazepam* is used alone or together with other medicines to treat certain seizure (convulsive) disorders (e.g., Lennox-Gastaut syndrome, akinetic or myoclonic seizures). It is also used to treat panic disorder in some patients. Clonazepam is a benzodiazepine. Benzodiazepines belong to the group of medicines called central nervous system depressants, which are medicines that slow down the nervous system.

Lamictal - *Lamotrigine* is used alone or together with other medicines to help control certain types of seizures (e.g., partial seizures, tonic-clonic seizures, or Lennox-Gastaut syndrome) in the treatment of epilepsy. This medicine cannot cure epilepsy and will only work to control seizures for as long as you continue to take it. It can also be used in the treatment of bipolar disorder (manic-depressive illness) in adults older than 18 years of age.

Lexapro - *Escitalopram* is used to treat mental depression and generalized anxiety disorder (GAD). Escitalopram belongs to a group of medicines known as selective serotonin reuptake inhibitors (SSRIs). These medicines are thought to work by increasing the activity of the chemical serotonin in the brain.

Librium - *Chlordiazepoxide* is used to relieve symptoms of anxiety, including nervousness or anxiety that happens before a surgery. It may also be used to treat symptoms of alcohol withdrawal. Chlordiazepoxide is a benzodiazepine. Benzodiazepines belong to the group of medicines called central nervous system depressants, which are medicines that slow down the nervous system.

Loxitane - *Loxapine* is an antipsychotic medication. It affects the actions of chemicals in your brain. Loxapine is used to treat schizophrenia.

Ludiomil - *Maprotiline* is an antidepressant. Maprotiline affects chemicals in the brain that may become unbalanced and cause depression. Maprotiline is used to treat major depressive disorder, depressive neurosis and manic-depression illness.

Lunesta - Lunesta is a sedative, also called a hypnotic. It affects chemicals in the patient's brain that may become unbalanced and cause sleep problems. Lunesta is used to treat insomnia. This medication causes relaxation to help patients fall asleep and stay asleep.

Moban - *Molindone* is an antipsychotic medication. It affects the actions of chemicals in the patient's brain. Molindone is used to treat schizophrenia.

Namenda - Namenda reduces the actions of chemicals in the brain that may contribute to the symptoms of Alzheimer's disease. Namenda is used to treat moderate to severe dementia of the Alzheimer's type.

Nembutal - *Pentobarbital* is in a group of drugs called barbiturates (bar-BIT-chur-ates). Pentobarbital slows the activity of the patient's brain and nervous system. Pentobarbital is used short-term to treat insomnia. Pentobarbital is also used as an emergency treatment for seizures, and to cause patients to fall asleep for surgery.

Norpramin - *Desipramine* is a tricyclic antidepressant. Desipramine affects chemicals in the brain that may become unbalanced. Desipramine is used to treat symptoms of depression.

Orap - *Pimozide* is used to treat the symptoms of Tourette's syndrome. It is meant only for patients with severe symptoms who cannot take or have not been helped by other medicine. Pimozide works in the central nervous system to help control the vocal outbursts and uncontrolled, repeated movements of the body (tics) that interfere with normal life. It will not completely cure the tics, but will help to reduce their number and severity.

Pamelor - *Nortriptyline* is in a group of drugs called tricyclic antidepressants. Nortriptyline affects chemicals in the brain that may become unbalanced. Nortriptyline is used to treat symptoms of depression.

Parnate - *Tranylcypromine* is a monoamine oxidase inhibitor (MAOI) that works by increasing the levels of certain chemicals in the brain. Tranylcypromine is used to treat major depressive episode in adults. This medication is usually given after other anti-depressants have been tried without successful treatment of symptoms. Tranylcypromine will not treat bipolar disorder (manic depression).

Paxil - Paxil is an antidepressant in a group of drugs called selective serotonin reuptake inhibitors (SSRI). It works by restoring the balance of serotonin, a natural substance in the brain, which helps to improve certain mood problems. Paxil is used to treat depression, obsessive-compulsive disorder,

anxiety disorders, post-traumatic stress disorder, and premenstrual dysphoric disorder.

Prosom - *Estazolam* is in a group of drugs called benzodiazepines. Estazolam affects chemicals in the brain that may become unbalanced and cause sleep problems (insomnia). Estazolam is used to treat insomnia symptoms, such as trouble falling or staying asleep.
Provigil – *Modafinil* is a medication that promotes wakefulness. It is thought to work by altering the natural chemicals (neurotransmitters) in the brain. Provigil is used to treat excessive sleepiness caused by sleep apnea, narcolepsy or shift work sleep disorder.

Prozac - Prozac is an antidepressant in a group of drugs called selective serotonin reuptake inhibitors (SSRIs). Prozac affects chemicals in the brain that may become unbalanced and cause depression, panic, anxiety, or obsessive-compulsive symptoms. Prozac is used to treat major depressive disorder, bulimia nervosa (an eating disorder) obsessive-compulsive disorder, panic disorder, and premenstrual dysphoric disorder (PMDD). Prozac is sometimes used together with another medication called olanzapine (Zyprexa) to treat depression caused by bipolar disorder (manic depression). This combination is also used to treat depression after at least 2 other medications have been tried without successful treatment of symptoms.

Remeron - Remeron is a tetracyclic antidepressant. It affects chemicals in the brain that may become unbalanced and cause depression. It is thought to increase the activity of norepinephrine and serotonin, which help elevate mood. Remeron is used to treat major depressive disorder.

Restoril - Restoril belongs to a group of drugs called benzodiazepines. It affects chemicals in the brain that may become unbalanced and cause sleep problems. Restoril is used to treat insomnia symptoms, such as trouble falling or staying asleep.

Risperdal - Risperdal is an antipsychotic medication. It is an "atypical antipsychotic." It works by changing the effects of chemicals in the brain. Risperdal is used to treat schizophrenia and symptoms of bipolar disorder (manic depression). It is also used in autistic children to treat symptoms of irritability.

Ritalin - Ritalin is a mild central nervous system stimulant. It affects chemicals in the brain and nerves that contribute to hyperactivity and impulse control. Ritalin is used to treat attention deficit disorder (ADD), attention deficit hyperactivity disorder (ADHD), and narcolepsy (an uncontrollable desire to sleep). When given for attention deficit disorder, Ritalin should be an integral part of a total treatment program that includes psychological, educational, and social measures.

Seroquel - Seroquel is an antipsychotic medication. It works by changing the actions of chemicals in the brain. Seroquel is used to treat schizophrenia in adults and children who are at least 13 years old. It is used to treat bipolar disorder (manic depression) in adults and children who are at least 10 years old. Seroquel is also used together with antidepressant medications to treat major depressive disorder in adults.

Sonata - Sonata is a sedative, also called a hypnotic. It affects chemicals in the patient's brain that may become unbalanced and cause sleep problems. Sonata is used to treat insomnia. This medication causes relaxation to help patients fall asleep and stay asleep.

Strattera - Strattera affects chemicals in the brain and nerves that contribute to hyperactivity and impulse control. Strattera is used to treat attention deficit hyperactivity disorder (ADHD).

Surmontil - *Trimipramine* is in a group of drugs called tricyclic antidepressants. Trimipramine affects chemicals in the brain that may become unbalanced. Trimipramine is used to treat symptoms of depression.

Symbyax - Symbyax (fluoxetine and olanzapine) contains a combination of fluoxetine and olanzapine. Fluoxetine is an antidepressant in a group of drugs called selective serotonin reuptake inhibitors (SSRIs). Olanzapine is an antipsychotic medication. These drugs affect chemicals in the brain. Symbyax is used to treat depression caused by bipolar disorder (manic depression). Symbyax is also used to treat depression after at least two other medications have been tried without successful treatment of symptoms.

Symmetrel - *Amantadine* is an antiviral medication. It blocks the actions of viruses in your body. Amantadine is used to treat and to prevent influenza A (a viral infection). There may be some flu seasons during which amantadine is not recommended because certain flu strains may be resistant to this drug. Amantadine is also used to treat Parkinson's disease and "Parkinson-like" symptoms such as stiffness and shaking that may be caused by the use of certain drugs.

Tegretol - Tegretol is in a group of drugs called anticonvulsants. It works by decreasing nerve impulses that cause seizures and pain. Tegretol is used to treat certain types of seizures associated with epilepsy, the treatment of the nerve pain associated with true trigeminal neuralgia and diabetic neuropathy. It is also used to treat bipolar disorder.

Tofranil - *Imipramine* is in a group of drugs called tricyclic antidepressants. Imipramine affects chemicals in the brain that may become unbalanced. Imipramine is used to treat symptoms of depression.

Tofranil – PM - Tofranil is used to treat depression. It is a member of the family of drugs called tricyclic antidepressants. Tofranil is also used on a short-term basis, along with behavioral therapies, to treat bed-wetting in children aged 6 and older. Its effectiveness may decrease with longer use. Some doctors also prescribe Tofranil to treat bulimia, attention deficit disorder in children, obsessive-compulsive disorder and panic disorder. Tofranil-PM, which is usually taken once daily at bedtime, is approved to treat major depression.

Tranxene T-Tab - *Clorazepate* is in a group of drugs called benzodiazepines. Clorazepate affects chemicals in the brain that may become unbalanced and cause anxiety or seizures. Clorazepate is used to treat anxiety disorders, partial seizures, or alcohol withdrawal symptoms.

Trileptal - Trileptal is in a group of drugs called anticonvulsants, or antiepileptic drugs. It works by decreasing nerve impulses that cause seizures. Trileptal is used to treat partial seizures in adults and children with epilepsy who are at least 2 years old. It may be used alone or in combination with other medicines.

Valium - Valium is in a group of drugs called benzodiazepines. It affects chemicals in the brain that may become unbalanced and cause anxiety. Valium is used in the management of anxiety disorders. It may also be used to treat agitation, shakiness, and hallucinations during alcohol withdrawal and to relieve certain types of muscle pain.

Vivactil - *Protriptyline* is in a group of drugs called tricyclic antidepressants. Protriptyline affects chemicals in the brain that may become unbalanced. Protriptyline is used to treat symptoms of depression.

Wellbutrin – Wellbutrin (*bupropion*) is an antidepressant medication. It works in the brain to treat depression. Wellbutrin is used to treat major depressive disorder and seasonal affective disorder. At least one brand of bupropion (Zyban) is used to help people stop smoking by reducing cravings and other withdrawal effects.

Wellbutrin XL - *Bupropion* is used to treat mental depression. It is also used as part of a support program to help people stop smoking. This medicine may also be used to prevent depression in patients with seasonal affective disorder, which is sometimes called winter depression. Bupropion is sold under

different brand names for different uses.

Xanax - Xanax is in a group of drugs called benzodiazepines. It affects chemicals in the brain that may become unbalanced and cause anxiety. Xanax is used to treat anxiety disorders, panic disorders and anxiety caused by depression.

Zoloft - Zoloft is an antidepressant in a group of drugs called selective serotonin reuptake inhibitors (SSRIs). Zoloft affects chemicals in the brain that may become unbalanced and cause depression, panic, anxiety, or obsessive-compulsive symptoms. Zoloft is used to treat depression, obsessive-compulsive disorder, panic disorder, anxiety disorders, post-traumatic stress disorder (PTSD) and premenstrual dysphoric disorder (PMDD).

Zonegran - Zonegran is a sulfa drug with anti-convulsant effects. Zonegran is used together with other anti-convulsant medications to treat partial seizures in adults with epilepsy. Partial seizures are a form of epilepsy in which neural disturbances are limited to a specific region of the brain and the victim remains conscious throughout the attack.

Zyprexa - Zyprexa (*olanzapine*) is an atypical antipsychotic medication. Exactly how it works is not known. It is thought to work by changing the actions of certain chemicals in the brain. Zyprexa is used to treat the symptoms of psychotic conditions such as schizophrenia and bipolar disorder (manic depression) in adults and children who are at least 13 years old. Zyprexa is sometimes used together with another medication called fluoxetine (Prozac, Sarafem). This combination is also used to treat depression after at least two other medications have been tried without successful treatment of symptoms.

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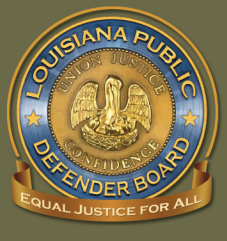

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